A sociological analysis of an area-based health initiative: a vehicle for social change?

Thesis submitted in accordance with the requirements of the University of Chester for the degree of Doctor in Philosophy by Katie Powell

November 2012

Acknowledgements

First and foremost, I would like to thank Miranda Thurston for her constant support. The inspiration and encouragement she provided made this study possible. Sincere thanks are also due to Daniel Bloyce, who provided continuous motivation and sociological rigour to the project, and to Julie Webster for her advice and support. I would also like to thank the University of Chester and NHS Western Cheshire for funding this research.

Several colleagues at the University of Chester provided invaluable help to the project. I am grateful to Cathy Perry and Rebecca Mead for their advice and practical help and to Simon Alford, Jess Hitchcock and Deanna Hughes for helping with the administration of this project. I would also like to express my thanks to colleagues at the University of Sheffield who have supported this work.

The staff involved in Target Wellbeing, who provided on-going support for this study, deserve a special thank you. Their insight was vital to the development of this research. I am also grateful to the residents of Ellesmere Port who gave up their time and shared their experiences for the benefit of this project. I hope that the study reflects the stories that participants shared with me.

Finally, I would like to acknowledge the friends and family who have supported my work in different ways: Mum, Peter, Anna, Chris, Triss, Dad and Phill.

Table of Contents

List of figures

List of tables

List of Abbreviations

- BIG – The BIG Lottery
- GIS – Geographical information systems
- GP – General practitioner
- HAZ – Health Action Zones
- IMD – Indices of multiple deprivation
- LGR – Local government reorganisation
- LSOA – Lower super output areas
- LSP – Local strategic partnership
- NDC – New Deal for Communities
- NWPHO – North West Public Health Observatory
- ONS – Office for National Statistics
- PCT – Primary care trust
- SRB – Single Regeneration Budget
- The Port – Ellesmere Port
- TOC – Theory of change
- TW – Target Wellbeing
- VCS – Voluntary and community sector
- WHO – World Health Organisation

Abstract

This thesis explores the implementation of an area-based health improvement initiative in the north west of England called Target Wellbeing. In the decades before Target Wellbeing was commissioned in 2007, health inequalities between people living in different areas of the UK had been widening. ABIs were identified by the Labour Government as a key tool for improving the health and wellbeing of residents in areas of socio-economic disadvantage and addressing inequalities in health. ABIs such as this have been well evaluated but there remains no firm evidence about the ability of such initiatives to improve health or to reduce health inequalities. In addition to the problems associated with evaluation, the processes through which ABIs might be used to influence change are not well understood and the value of using area-based services to improve health has been taken for granted. There is little understanding about the processes through which service provider partnerships might develop and limited knowledge about the processes through which residents might develop relations with providers. The key aim of this research was to examine the social processes through which ABIs develop over time.

Using a case study approach, the research examined one Target Wellbeing programme as a social figuration of interdependent people. Ethnographic methods, including documentary analysis, non-participant observation and interviews, were used to explore the processes and networks that mediated the planned public health development. The study also drew on relevant quantitative data to describe changes over time. Ideas from figurational sociology were used as sensitising concepts in the development of a substantive theory about the processes through which ABIs develop. The study developed theoretical insight into processes of joint working that helps to explain why, in the context in which services are commissioned and performance managed, provider co-ordination is unlikely to be implemented as planned. It also provided a more sociologically adequate account of the ways in which relations between residents and providers were influenced by the history of relations in the town. Changes to residents' relations with other residents and providers in the town influenced a greater sense of control over their circumstances. These findings demonstrate that, in relation to public health policy and practice, ABIs might more usefully be conceptualised as a series of interrelated processes that might be used to establish the preconditions for influencing change among residents. However, the study showed that interventions targeted at a small part of much wider networks of interconnected people are unlikely to influence sustained changes for residents in deprived areas.

Chapter 1

Introduction

1.1 Introduction

This thesis explores the implementation of an area-based health improvement initiative in the north west of England called Target Wellbeing (TW). This chapter sets out the background and rationale for the study, introducing the research problems that were investigated. The chapter summarises what is already known about area-based initiatives (ABIs) and identifies where this research can develop understanding about the phenomenon. The chapter also provides an overview of the research design and sets out the format of the thesis.

1.2 Background to the research

In the decades before TW was commissioned in 2007, health inequalities between people living in different areas of the United Kingdom (UK) had been widening. Health inequalities between the UK regions widened across the early 1980s (Whitehead, 1988) and 1990s (Dorling, 1997) and inequalities widened at a ward level too across the same period (Phillimore, 1994). Improvement of the health of the population was identified as a central concern in public health policy at the time (Department of Health, 2000; Milburn, 2002, November 20): increasing life expectancy and disability-free life expectancy were identified as key goals in the serving Labour Government's health strategy (Department of Health, 1999b). Addressing inequalities in health was also identified as a public health policy priority. "Improving the health of the worst off" (Department of Health, 1999b, p. para. 1.15) and narrowing the gap in health outcomes between the country's richest and poorest people were repeatedly identified as key priorities in government policy and publications under Labour (Office of the Deputy Prime Minister, 2005).

ABIs were identified by the Labour Government as a key tool for the delivery of these polices (Department of Health, 1999b, 2003, 2004), as shown by the plethora of short-term (typically 2-7 years), localised initiatives during its 13-years in office. ABIs were defined by the Government as "publicly funded initiatives targeted on areas of social or economic disadvantage, which aim to improve the quality of life of residents and/or their future life chances and those of their children" (Government

Offices for the English Regions, no date). Areas of social and economic disadvantage were often defined in policy according to aggregated individual scores in relation to the indices of multiple deprivation (IMD) (Communities and Local Government, 2010). This conceptualisation of disadvantage was based on the idea that some "areas suffer from a combination of linked problems such as unemployment, low incomes, poor housing, high crime environment, bad health and family breakdown" (Social Exclusion Unit, 2001, p. 10). Although targeting areas of disadvantage as a means of addressing health inequalities was not a new idea, Labour ABIs were distinctive in their focus on 'social exclusion' as one of the key causes of health and social problems in these areas. This idea is examined in more detail in subsequent chapters but it is important to emphasise here that ABIs during this period were more focussed on social relations than the initiatives that preceded them in the sense that they were concerned with inadequate social participation in local services and community activities, lack of social integration among residents and a lack of power among some residents in relation to their circumstances (Coalter, 2007).

Although the term is used with increasing frequency in both policy and academic literature, there is no clear consensus as to what constitutes an ABI. The term has been used across a range of fields to describe public policy that targets geographical areas for improvement (Sullivan, Barnes, & Matka, 2006) and ABIs vary according to their aims, the type of activity carried out as part of the initiative, and the size of geographical areas targeted. Notwithstanding these differences, three interconnected themes have consistently shaped recent ABIs: namely the co-ordination of services at a local area level, involvement of the voluntary and community sector (VCS) in the delivery of local services, and participation of local people in those services. Planned service provider partnerships have a long history in UK public policy (Perkins, Smith, Hunter, Bambra, & Joyce, 2010) and the Labour Government sought to develop such partnerships in many areas of public services, particularly health (Department of Health, 2000). Local services, and the VCS in particular, were given a key role in addressing social exclusion in deprived areas (Department of Health, 1999b). It was suggested that contact with services was a means through which social exclusion (Blair, 1997) and consequently health (Department of Health, 2003) could be improved. It was against this background that TW, the initiative that was the focus of this research, was commissioned in 2008.

1.2.1 Target Wellbeing in Ellesmere Port

TW was funded by the BIG Lottery (BIG), which is responsible for distributing funds from The National Lottery to good causes. Although BIG is an independent body, it is sponsored by the Cabinet Office and, as such, receives policy direction from the Department for Culture, Media and Sport (2010). TW reflected many of the policy aspirations set out by the Labour Government. The initiative was targeted at 10 areas of disadvantage, defined by levels of physical, mental and economic wellbeing, across the North West. The main aims of the initiative were to increase levels of physical activity, promote healthy eating and improve mental wellbeing. Area-programmes, consisting of 8 to 10 projects, were developed in each of the targeted areas, led by a Programme Manager, to run between 2008 and 2012. The projects were primarily delivered through VCS organisations and a small number of statutory organisations and, addressing at least one of the main aims, ranged from community walking projects to back-to-work courses. There was a particular emphasis in the initiative strategy on collaborative working between providers at different projects and across different TW programmes. Targets were set by the co-ordinators of the initiative (a group of people involved in service co-ordination across different sectors) for the recruitment of residents to individual projects. 'Outcomes' that were deemed to reflect change in relation to healthy eating, physical activity and mental wellbeing were devised by funders and co-ordinators to be measured through an evaluation, separate and distinct from this research, that was targeted at the 92 TW projects delivered across the North West.

The TW area programme in Ellesmere Port was the focus of this research. Ellesmere Port is a town on the Wirral Peninsular in the north west of England situated between the cities of Liverpool and Chester. The 2010 IMD (based on data from 2008 and therefore most relevant to the period in which TW was commissioned) indicate that, in terms of overall deprivation, 12 lower super output areas (LSOAs) in Ellesmere Port fell within the 20% most deprived LSOAs in England; four of which were within the 10% most deprived LSOAs in England (Communities and Local Government, 2010). The TW programme in the town was made up of eight projects, delivered by six different organisations: five VCS organisations and one organisation (the local Healthy Living Centre) jointly funded by the local primary care trust (PCT) and the local authority. A brief description of the projects and the organisations that delivered them is provided in Table 1.1.

Table 1.1 Target Wellbeing projects in Ellesmere Port

Project name	Lead organisation	Project description
Footprints	Ellesmere Port Healthy Living Centre	Community walking project
Get Involved, Get Active	Age UK	Physical activity project for older people
Grab a bag	Ellesmere Port Healthy Living Centre	Subsidised fruit and vegetable bag scheme and nutrition sessions delivered in schools
Lots of Plots	Groundwork Cheshire	Food growing project
Mental Health and Wellbeing	CHAPTER	Project supporting people with severe and enduring mental health problems to return to work
Out and About	Groundwork Cheshire	Food growing project
Pathways to Employment	Pathways Community Interest Company	Project supporting people who have been long-term unemployed back in to employment
Workplace Wellbeing	Health@Work	Project supporting people experiencing health-related work problems

Appendix 11 shows a description of the activities provided by each project. The descriptions were written by the project lead organisations for their BIG Lottery funding application.

1.3 Study rationale

This research originated through discussions between the team responsible for delivering TW in Ellesmere Port (NHS Western Cheshire) and public health researchers at the University of Chester. Staff in the Public Health team within NHS Western Cheshire perceived that additional public health funding from TW, targeted at one town in the region, was unprecedented and very welcome. Consequently,

staff wanted to invest in research and evaluation to assess its potential. Staff at the University of Chester identified an opportunity for research into an area of public health policy that had received sustained evaluation but minimal research attention. ABIs such as TW have been subject to evaluation but there remains no firm evidence about the ability to use such initiatives to improve health (Judge & Bauld, 2006), or to reduce health inequalities (Thomson, 2008a). The lack of evidence might be attributed, in part, to the difficulty of evaluating complex interventions, given that, for example, ABIs commonly comprise a diverse range of programmes and activities (Thomson, 2008a). Furthermore, as Dooris (2004) has highlighted, ABIs are usually delivered in settings where other initiatives and policies are operating, which not only complicates programme implementation but also makes it difficult to attribute any observed changes to a particular intervention. Perhaps due to this complexity, ABI evaluations have been limited to descriptive accounts, which lack explanatory power.

In addition, the processes through which ABIs might be used to influence change are not well understood and the value of using area-based services to improve health has been taken for granted (O'Dwyer, Baum, Kavanagh, & Macdougall, 2007). There is little understanding about the processes through which service provider partnerships might develop and limited knowledge about the processes through which residents might develop relations with providers. Within the existing literature, there is limited sociological explanation for why ABI partnerships have not developed as expected and there are calls (Ansari & Weiss, 2006) for more research that explores the context in which partnerships operate in order to make sense of what takes place. Research that has explored what takes place in ABI partnerships has failed, thus far, to take adequate account of the historical social context in which partnerships develop. Furthermore, resident 'engagement' with services has not been explored as a sociological process and as a consequence, there is uncertainty about who has benefited from ABIs (Lawless & Dabinett, 2000). There appears to be scope therefore, to develop more theoretically informed understanding about the ways in which ABIs unfold when introduced into an area, informed by examining changes over time. The actions and events that take place as part of an ABI need to be better understood to assess whether such initiatives might be used as a vehicle for social change among residents in deprived areas, as anticipated in policy.

As a public health researcher with knowledge and research experience of initiatives targeted at socioeconomically deprived areas, I was drawn to this project because of the opportunity it provided for an-in depth study into a newly developing initiative. Having previously been involved in short-term evaluations of area-based projects delivered through the UK's Children's Fund and Sure Start programmes, I was eager to undertake a more comprehensive exploration of a similar type of project from its inception. With a background in sociology, I had been somewhat frustrated by the limited opportunity to apply sociological ideas within the evaluation work I had completed prior to this project. The parameters of my previous work had largely been set by evaluation commissioners needing to measure and report the impact of their work to funders in terms of 'outcomes'.

Prior to starting the project, although I had no paid experience as a service provider, I had been involved as a volunteer in a number of community groups, including the Girl Guides and a small independent charity providing leisure activities for disabled children. These experiences gave me some insight into the workings of community organisations (such as the funding and staff recruitment processes) and I was interested in the ways in which work priorities for such organisations were set. I was particularly interested in exploring how the social activities within TW projects (and other voluntary sector activities that I had been involved with) might be related to health, as anticipated in policy documents. My sociological background made me keen to explore the idea of social capital (a concept related to ABIs in a number of policy documents during the period in which TW was commissioned, as discussed in Chapter 2). I had used Bourdieu's concepts of social and cultural capital within my postgraduate dissertation to explore experiences of a mentoring scheme designed to encourage young people from socio-economically deprived areas to apply to university. The project used a qualitative approach to explore to what extent and in what ways university mentors were able to influence school leavers' perceptions of higher education. My findings indicated that it was difficult for mentors to influence change among mentees within a short-term project. Explaining this in terms of capital, I drew the conclusion that generation of cultural capital, which might influence aspirations towards higher education, was dependent on a much wider group of people outside of the mentoring relationship. Within the present thesis, I was interested in exploring how social contact between TW providers and residents (which might reflect mentoring relationships to some extent) could influence change.

These ideas shaped the ways in which the project was designed. The sociological orientation of the research reflected my own interests in the social dimensions of human decisions and actions. The ways in which I endeavoured to manage the influence of my own experiences on the study are described in Chapter 5. The key aim of this research was to examine the social processes through which TW developed over time in order to assess the extent to which it had been a vehicle for social change. In order to interrogate policy ideas about challenging social exclusion, social change was defined in terms of changing relations among targeted residents and between residents and service providers. A number of more detailed research questions emerged over the course of the study:

1. What are the processes through which TW is commissioned and through what processes do plans and strategies develop?
2. How do relations between service providers in an area develop over time when an ABI is introduced and what consequences emerge from these relations?
3. How do relations between providers and residents develop over time when an ABI is introduced into an area?
4. What consequences emerge for residents who participate in an ABI and how do they relate to the way in which relations develop between residents and providers?

1.4 Research design

This research examined the development of TW in Ellesmere Port prospectively in order to examine the processes through which such an initiative is developed. Using a case study approach, the research explored the Ellesmere Port setting as a social network of interdependent people. This conceptualisation of the setting is explained in more detail in Chapters 4 and 5. Ethnographic methods were used to explore the social processes and networks that mediated the planned development. The study predominantly used qualitative methods, but also drew on relevant quantitative data to describe changes in the area over time. A combination of specific data collection methods was used:

- documentary analysis,
- semi-structured interviews with initiative providers and residents,

- non-participant observation of initiative events and activities.

The research was informed by a sociological perspective and drew on ideas from figurational sociology. Figurational sociology, a perspective which has been used to examine organisational change within the NHS (Dopson & Waddington, 1996; Mowles, 2011), has not been applied to the field of public health in general or ABIs in particular. It provides a framework for the analysis of social phenomena based on networks of interdependency (or figurations) between people (Elias, 1978, 1991). One of the central premises of figurational sociology is that the interdependence of people both reflects and stimulates a complex interweaving of actions and intentions that results in a number of consequences that no one group or individual intended (Elias, 1978). Figurational ideas therefore provide a useful way of conceptualising communities as dynamic, unbounded networks (or figurations) of people. Examining the figurations in which ABI service providers and targeted residents are immersed presents an opportunity to explain more adequately why ABIs have not developed as anticipated in policy. The study had a commitment to a grounded theory approach (Strauss & Corbin, 1998) while also testing out a number of figurational ideas, using them as sensitising concepts to develop a substantive theory about the processes through which ABIs develop.

Figurational ideas were used to sensitise the researcher to particular social processes taking place at every stage of the analysis. In this respect, a "constant interplay" was sought between generating new ideas directly from collated data and testing existing explanations of human behaviour (Elias, 1978, p. 34). The study sought to develop a plausible account of the ways in which an ABI unfolds when introduced into a new area, uncovering planned and unplanned consequences. By better understanding the assumptions and expectations underpinning the actions of ABI providers and targeted residents policy makers and service commissioners can develop more adequate expectations from ABIs and, furthermore, might be able to better control the social processes through which ABIs develop. The research was jointly funded by NHS Western Cheshire and the University of Chester via a Gladstone Bursary.

1.5 The structure of the thesis

In the next two chapters, the background and rationale for the study is developed by examining what is already known about ABIs. Chapter 2 explores the development of ABIs under the last Labour government. It takes a historical perspective, situating

the research in relation to longer-term social processes. This enables identification of the 'problems' with which ABIs have been associated and a better understanding of what they were intended to change. Chapter 3 examines key debates relating to ABIs, critically examining the ways in which they have been understood to date in the academic literature. Empirical and theoretical studies are reviewed in order to assess the adequacy of existing knowledge about how ABIs develop over time. Chapter 4 presents the theoretical ideas that informed the study and discusses their potential utility in developing a substantive theory about ABI development. Chapter 5 outlines the research process and explains the choices made in relation to methodology. The next five chapters are used to present the findings from the case study data. Chapter 6 describes the social context in which TW activities unfolded. A historical perspective is taken in order to better understand the social conditions in the town that influenced residents' health. Chapter 7 examines the social processes through which TW was commissioned, which provided an opportunity to explore the ways in which early relations between providers developed. Following on from this, Chapter 8 examines the ways in which relations between providers developed once TW funding had been obtained by providers. Chapter 9 looks at the ways in which relations between residents and TW providers developed over the course of the initiative. The consequences that emerged from these relations are described in Chapter 10 to explain how changes developed among residents. The interpretation developed across the findings chapters is explained in sociological terms in Chapter 11. This chapter seeks to bring together the explanatory concepts introduced in the findings chapters to form a coherent theoretical account for understanding the development of TW, which has wider theoretical resonance to other similar ABIs. The final chapter of the thesis, Chapter 11, examines the strengths and limitations of the study, and discusses the implications of the findings in terms of public health policy and practice and future research into ABIs.

Chapter 2

The emergence of area-based initiatives

2.1 Introduction

This chapter explores the development of ABIs under the last Labour Government. It examines the UK context where relevant, but, given the differences across devolved national administrations, the primary focus is on the English policy context from which TW emerged. The reasons for examining the policy context are twofold. First, as Buck (2001, p. 2252) argues, reviewing the policy context "helps to clarify what is at issue" for policy makers. That is, it enables identification of the 'problems' with which ABIs have been associated and a better understanding of what they were intended to change. Second, exploring the development of policy issues over time provides an opportunity to interrogate how these social issues came to be defined as problems, identifying underlying assumptions and critically evaluating the ways in which ABIs have been understood. The chapter starts by exploring the development of knowledge in relation to health inequalities before offering a brief history of ABIs in England. Finally, key aspects of Labour's ABI policy are examined.

2.2 The historical context for the study of health inequalities

Knowledge about the extent of inequalities in health across the UK population, as well as knowledge about their causes, shaped Labour's use of ABIs. An overview of the ways in which research into health inequalities has developed over time, with an emphasis on the role of place in this knowledge, provides insight into some of the ideas underpinning recent ABIs.

There is debate about the extent to which knowledge about health inequalities existed before the nineteenth century (Whitehead & Drever, 1997). Some specialists in this field (for example Macintyre, MacIver, & Sooman, 1993) identify John Graunt as the first researcher to observe variations in mortality rates by geographical area in the 1600s. However, interest in measuring health inequalities burgeoned during the nineteenth century. This was influenced, to a large degree, by new forms of relations between different socio-economic groups following industrial revolution.

The towns and cities which grew out of industrialisation brought greater numbers of people into closer physical proximity in their living and working lives (Baggott, 2000). People also became increasingly dependent on a growing number of others for their earnings and welfare with the increasing division of labour (Elias, 1994). Communicable diseases that had hitherto been largely confined to lower socio-economic groups, including cholera and typhoid, became of increasing concern to people in higher socio-economic groups, both because of the increased risk of infection and because of an increasing interdependency of such groups in terms of labour (Baggott, 2000). Such changes strengthened the impetus to identify the causes of such diseases and the reasons for their proliferation in the towns and cities.

Understanding about health inequalities has also been shaped by the means available to identify and measure differences in health. As Mackenbach (2006) and Julia and Valleron (2009) highlight, developments in epidemiological techniques in the UK (William Farr and John Snow), France (Louis René Villermé) and Germany (Rudolf Virchow) during the middle of the nineteenth century made it possible to explore differences across the population's health in detail for the first time. In a review of developing policy interest in economically and socially deprived areas over the last 100 years, Glennerster, Lupton, Noden and Power (1999) demonstrate how knowledge about inequalities continued to be shaped by the tools available for classification and measurement throughout the twentieth century. They also argue that research into poverty and inequality has often focussed on particular geographical areas because they constitute a convenient unit for research.

In the UK, Chadwick's (1843) research made use of new epidemiological techniques to demonstrate a link between sanitary conditions in densely populated urban dwellings and the prevalence of infectious diseases. Other research carried out during this period by Engels (1844) emphasised the role that working conditions and poverty played in the development of ill-health in poorer areas. This research contributed to the movement for public health action. Following the publication of Chadwick's report, there was a sustained period of campaigning by pressure groups for improvements to the living conditions in England's cities, notably from within the newly formed manufacturing classes (Szreter & Woolcock, 2004). One of the outcomes of the ensuing debate was the Public Health Act of 1848, compelling local authorities to provide adequate sanitation and water supplies to manage the spread of infectious disease in urban areas (Orme, Powell, Taylor, & Grey, 2007). This

period of reform, focussed on living conditions in poorer, urban areas, formed the basis for the development of the modern public health movement in the UK (Fraser, 2009; Orme, et al., 2007).

Over the next century, measurement and analysis of health inequalities within the UK was shaped by shifting conceptualisations of health that partly reflected a shift in the major causes of death from infectious diseases to chronic degenerative diseases. The focus placed on ill-health in nineteenth-century research gradually developed into an interest in broader experiences of health, as encapsulated by the definition of health proposed by the World Health Organization (WHO) in 1948. The definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1948, p. 1) is still widely referred to in international and UK policy and research.

The variety of proxy measures for health now used in UK research reflects growing appreciation of its complexity. Mortality (see for example Department of Health, 2010a) and morbidity (for example Manor, Matthews, & Power, 1997) are still widely used indicators of health status but there is growing interest in indicators that reflect the impact of health status on people’s lives, such as self-rated health (Manor, et al., 1997) and sickness absence from work (North, Syme, Feeney, Shipley, & Marmot, 1996). There has also been growing research interest in wellbeing and quality of life (Steuer & Marks, 2008). The Office for National Statistics (ONS) recently published a report on the state of the UK’s wellbeing as part of a programme established in 2010 to “develop and publish an accepted and trusted set of National Statistics which help people understand and monitor well-being” (Self, Thomas, & Randall, 2012). Although these concepts more adequately capture the physical, psychological and social dimensions of health, appreciation of its complexity has made the difficulties of measuring and comparing ‘health’ across different groups more apparent (Cameron, Mathers, & Parry, 2008). Reflecting this difficulty, the International Wellbeing Group (2006), in its manual for the measurement of wellbeing, identified over 800 instruments designed to measure quality of life.

Growing research interest in experiences of health and wellbeing has shown the determinants of health to be diverse and unequally distributed across the population. Work started in the 1970s by Marmot and colleagues (Marmot, Rose, Shipley, & Hamilton, 1978) transformed understanding about the determinants of health by revealing a social gradient in life expectancy in relation to occupational

class which the research team partly attributed to variations in levels of job control. In 1971, evidence of differential access to healthcare started to emerge (for example Tudor Hart, 1971) and other research has since shown that survival rates from cancers (Korgevinas & Porta, 1997) and heart attacks (Greenwood, Packham, Muir, & Madeley, 1995) are linked to socio-economic status. Across a range of different disciplines, researchers have explored the social processes shaping health differences across the UK population according to socio-economic circumstances (Hills et al., 2010; Roberts & Power, 1996), education (Archer, Hutchings, & Ross, 2003), social status (Savage, 2003), gender (Bartley, 2004) and ethnicity (Nazroo, 2003). More recently, comparisons across developed countries have shown that health and social inequalities are not an inevitable consequence of industrial capitalism, supporting the case that such inequalities might be amenable to change (Wilkinson & Pickett, 2010).

Health differences according to geography have formed part of the understanding about the determinants of health. Following Chadwick's early work, there has been sustained interest in mapping different experiences of health and illness in the UK (Curtis & Rees Jones, 1998; Gatrell et al., 2000; Joshi et al., 2000). Macintyre, Ellaway and Cummins (2002) describe how developments in survey techniques and the emergence of large national datasets in the post war period, such as those derived from the Longitudinal Study in England and Wales, made it possible to produce area indices. Differences in individual health outcomes at the area level have to some extent mirrored the spatial distribution of socio-economic inequality (Dorling, Mitchell, Shaw, Orford, & Smith, 2000) but, as Powell, Boyne and Ashworth (2001) have noted, aggregation of individual-level data as a measure of area poverty conceals differences across families and people. In the 1970s, Townsend (1979) argued that using aggregated measures to identify the 50% most economically deprived areas in the country left a larger number of people living in poverty outside of these areas.

Towards the end of the twentieth century, researchers started to examine whether area characteristics had an 'independent' effect on people living there (Jones & Duncan, 1995; Powell, et al., 2001; Stafford, Gimeno, & Marmot, 2008). In these studies indicators including socio-economic status and diet were categorised as individual characteristics and their impact on health controlled for to assess whether health outcomes could be attributed to the impact of living in a particular area. This separation of individual and area characteristics is however artificial. As others

(Dorling, 2010; Macintyre, et al., 1993) suggest, treating these indicators as independent variables ignores the ways in which individual characteristics are shaped by where people live. Criticism of such an atomistic approach to the wider determinants of health, which severs people form their social context, is well-established (Popay, Williams, Thomas, & Gatrell, 1998). Recent models within the literature that seek to explain the social determinants of health describe the interplay of a range of individual 'compositional' factors and contextual factors (Macintyre, et al., 2002; Solar & Irwin, 2007). This is also reflected in Dahlgren and Whitehead's (1991) depiction of the social determinants of health in the model shown in Figure 2.1. This model shows that the influences on health are multiple but, fails to show how they are interrelated. Part of the reason for this limited conceptualisation is the limited amount of theoretically-informed research that describes the inter-relationship between the determinants of health. Such models represent a view of reality as egocentric, artificially separating individual and social experiences.

When Labour came to power in 1997, research into the role of social networks in the development of health inequalities was gathering pace. In policy terms, this has often been encapsulated in interest in developing social capital (Swann & Morgan, 2002). Social capital is a frequently used concept in the health inequalities literature (Swann & Morgan, 2002), and has been used to explain variations in health outcomes between communities (Moore, Haines, Hawe, & Shiell, 2006). It is defined as the 'ability of actors to secure benefits by virtue of membership in social networks or other social structures' (Portes, 1998, p. 6). These ideas have informed the design of recent ABIs, as discussed below.

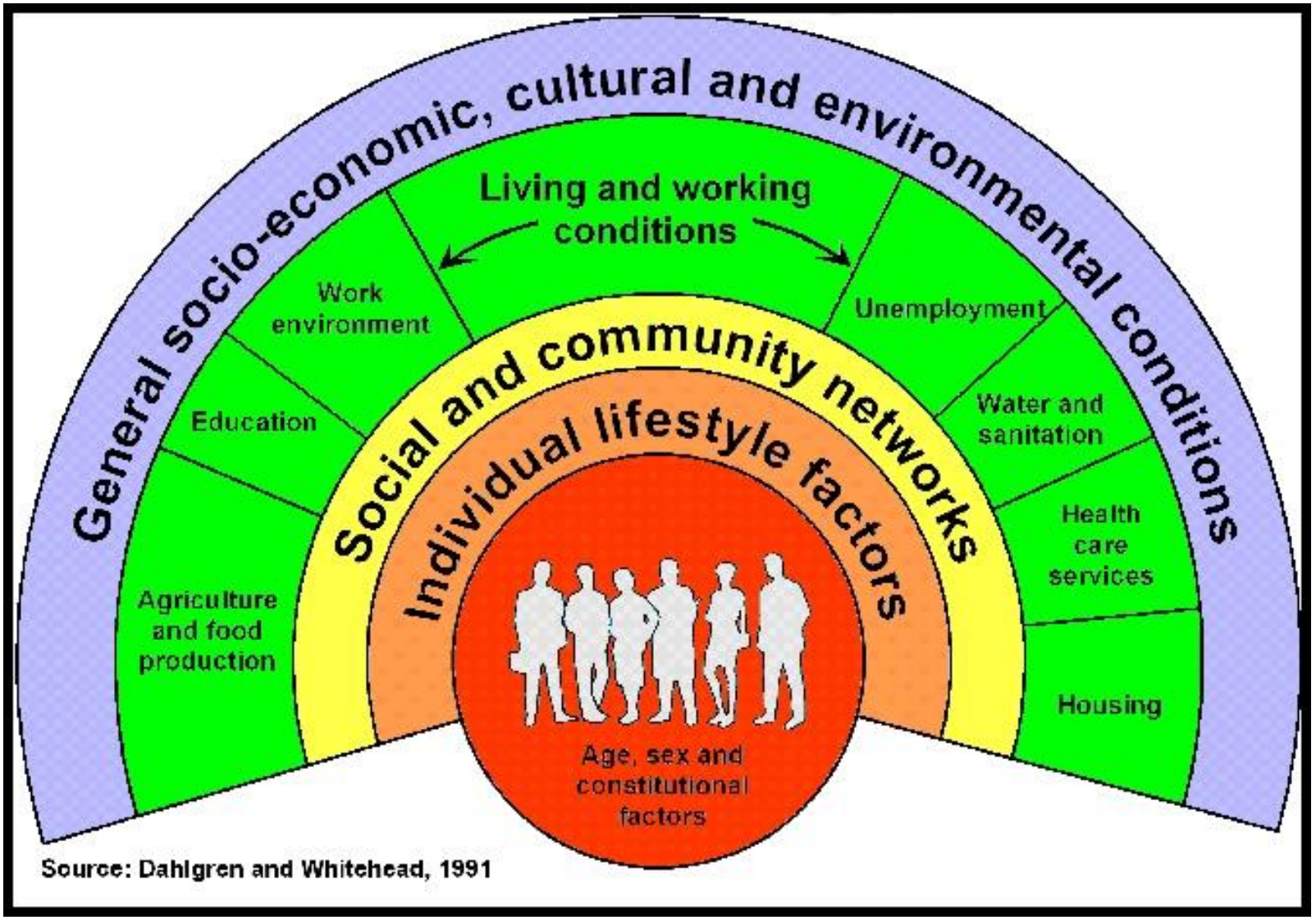


Figure 2.1 The Broad Determinants of Health, reproduced with permission from the Institute for Futures Studies (Dahlgren & Whitehead, 1991)

2.2.3 Widening health inequalities in the late twentieth century

Prior to 1997, research suggested that inequalities in health, measured in a variety of different ways, were widening. A review of health inequalities commissioned by the Labour Government of 1977, The Black Report, was important in bringing together this research (Black, Townsend, & Morris, 1980). The Report demonstrated a widening gap in life expectancy between the lowest and highest socio-economic groups in the UK between the 1960s and early 1970s. Across the 1980s (Whitehead, 1988) and 1990s (Dorling, 1997) research suggested that inequalities in life expectancy between the UK regions had continued to grow. Widening inequalities were observed at a ward level too. For example, Phillimore (1994) showed that absolute differences in mortality rates between less and more materially deprived wards in the north of England widened between 1981 and 1991. The Acheson Report (1998), commissioned by the incoming Labour Government in 1997, demonstrated that between the early 1970s and the early 1990s the difference in mortality rate between men of working age in the lowest and highest social classes went from two to three times higher. The gap in life expectancy between the highest and lowest social classes over a similar period was shown to increase by 0.6 years for men and by a year for women (Acheson, 1998). Acheson (1998) attributed growing health inequalities to the faster rate of health improvement among higher social classes, a trend which has since been observed by others (Mackenbach, 2006).

Across Labour's period of office, from baseline measures in 1997 the gap in life expectancy and infant mortality remained unchanged (Marmot, 2010). At the end of Labour's third term, the average difference in life expectancy between the poorest and richest areas in England in 2010 was seven years (Marmot, 2010). This average concealed bigger variations across smaller geographical areas. Analysis by the London Health Observatory (2010), for example, showed a gradual decline in life expectancy across different areas of London during this period such that a difference of almost 5 years was observed between towns only a few miles apart. In Western Cheshire life expectancy between men in the most economically deprived wards in 2009 was eight years lower than for men in the most affluent wards (Association of Public Health Observatories and Department of Health, 2009). Evidence suggests that illness and disability are even more unevenly distributed: the average difference in disability-free life expectancy across England is 17 years (Marmot, 2010).

Understanding why health inequalities widened at the end of the twentieth century, and why a more recent halt in this trend has been observed, is difficult because the processes shaping these trends are interrelated. Widening income inequality in the UK seems to form part of the explanation. A rise in income inequality in the 1980s was well documented (Goodman, 1997) and more recent research has shown that this trend continued into the 1990s (Hills, et al., 2010). The increasing geographical concentration of poverty in the UK, as measured by the number of unemployed people per electoral ward (Glennerster, et al., 1999) and by the proportion of people with incomes lower than 60% of the national median (Marmot, 2010), has been linked to the development of worse health and social outcomes in some areas. As Coburn (2004) argues however, income is a proxy for a range of social conditions and the growing concentration of poverty in some areas of the UK towards the end of the twentieth century reflected broader social changes, which have influenced the development of health and social problems in some areas. For example, McCulloch (2012) argues that sudden changes in labour demand and supply, with local job losses in some areas heavily dependent on declining industries, partly explains concentrations of unemployment in some areas, but he also argues that a decline in skills and ill health following labour market inactivity perpetuate the concentration of unemployment. A brief overview of the ways in which ABIs have been used as a policy response to these issues is presented below.

2.3 A broad history of UK area based initiatives

There has been a relatively sustained focus on geographical areas of poverty and disadvantage in English public health policy since the late 19th century but conceptualisation of the issues this policy has targeted has shifted over time, partly reflecting the complexity of the changing evidence base described above. Three broad areas of activity are identifiable within policy across this period relating to environmental, economic and social change. Policy interest in these activities has waxed and waned over time but, in reality, many interventions have straddled these interconnected areas of work. This section provides an overview of the changing policy targeted at ‘deprived’ areas related to health improvement.

Following the actions of early public health reformers in the nineteenth century described above, public health action in England across the first half of the twentieth century was focused on the development of health and welfare services (Baggott, 2000); enduring interest in place-based health improvement was visible in the

organisation of these services at an area level. Atkinson's (2000) analysis of UK urban policy in this period indicates that by the 1960s there was a perception in government that the problems of poverty in the immediate post-war period had been eradicated through the welfare state. The health and social problems which persisted in some areas were identified as isolated issues, reflecting the increasing trend for medicalisation and individualisation of health and social problems (Baggott, 2000; Conrad, 1992; Gabe, Bury, & Elston, 2004). Atkinson (2000) argues that this view emerged from a political commitment to Keynesian social democracy and an investment, on the part of the serving Labour Government, in seeing the welfare state succeed. There were, however, emerging concerns about meeting the rising costs of the relatively new NHS. Partly shaped by these concerns, health improvement through medical treatment came under increasing criticism towards the end of the century (Illich, 1977; McKeown, 1976) and interest was developing in alternative forms of health improvement through preventative action.

Throughout the late 1960s and 1970s a variety of government funded initiatives were launched. These initiatives focussed on the organisation of services in what the serving Home Secretary in 1968 described as "the poorest or most overcrowded parts of our cities and towns" (quoted in Barr, 2005). Interventions such as Community Development Projects, the Urban Programme and Education Priority Areas reflected interest in improving universal welfare provision in some areas, seeking to better manage and co-ordinate local public services (Stewart, 2001). For example, a series of projects were funded through the Urban Programme, launched in 1968, to supplement service provision, such as legal or family planning advice centres. From a survey of service providers funded through this initiative, Batley and Edwards (1974, p. 307) concluded that their primary aim was to improve access to services for people in the targeted areas by "experiment[ing] with new and alternative forms of provision." Thus the initiatives were focussed on supplementing mainstream services in deprived areas, where it was perceived that people needed encouragement and assistance to benefit from services that were deemed to be working effectively elsewhere.

During the 1980s there was a specific interest in economic regeneration, reflecting the prevailing neo-liberal ideology of the period (Lloyd & Black, 1993). A range of programmes in the 1980s focussed on property, land and economic regeneration in economically deprived areas (Dabinett, Lawless, Rhodes, & Tyler, 2004). For example, the Urban Development Corporations, launched in 1980 were tasked with

“bringing land and buildings into effective use, encouraging the development of existing and new industry and commerce, creating an attractive environment [and] ensuring that housing and social facilities are available to encourage people to live and work in the area” (English Partnerships: The National Regeneration Agency, 2008 para. 1.). In these initiatives, developing economic opportunities was identified as the key mechanism through which the wellbeing of people living in deprived areas could be improved.

Among public health advocates at this time, an interest in ‘healthy settings’ was emerging, reflecting the growing body of evidence to suggest that the social and physical environments in which people lived and worked were important for health. Initially, this had limited influence over UK government policy. A number of guiding principles for public health action were developed out of the first International Conference on Health Promotion in 1986 including a directive to “create supportive environments,” which focussed attention on the natural and built environments as well as social relations (World Health Organization, 1986, p. 2). These principles were most clearly demonstrated in the WHO-led Healthy Cities initiative, which were delivered through city plans which sought to co-ordinate service and business strategies among city councils, VCS organisations, universities and a host of other organisations within participating cities (Costongs & Springett, 1997).

By the early 1990s, some of these ideas had penetrated government-led ABIs, which had shifted away from a regeneration model based solely on economic growth. City Challenge partnerships and Single Regeneration Budgets (SRBs) were launched in the final years of the Conservative Government’s leadership, directed by a prime minister perceived by some to occupy more central political ground (Allmendinger & Tewdwr-Jones, 1997). These initiatives still seemed to be underpinned by the prevailing neo-liberal ideology, advocating reducing state intervention in welfare and promoting a large role for VCS and private sector providers. The programmes brought together public, private and VCS organisations expected to co-ordinate mainstream services such as education, health, and housing in deprived areas (Rhodes, Tyler, & Brennan, 2007). The development of multi-sector service provision partnerships was intended to deliver more comprehensive regeneration than had hitherto been achieved (Dabinett, et al., 2004), reflecting both dissatisfaction with the results of previous initiatives and an interest in improving the efficiency of mainstream services by harnessing the perceived expertise of private providers.

Similarly, the introduction of competitive bidding processes for ABI funding during this period reflected an ideological commitment to New Public Management (which shaped the governance of public sector services from the 1980s onwards, see for example Hood, 1995) and the introduction of market-based measures as a means of improving the efficiency of public services (Hunter, 2008). Specifically, competitive bidding was intended to generate innovative solutions to the problems in deprived areas (Hall, 2000; Power, Rees, & Taylor, 2005) and to improve the efficiency of mainstream services by ensuring that funds were allocated to areas in most 'need' of services (Hall, 2000). Such processes have, however, been criticised for rewarding areas capable of developing the best presented bids, rather than areas in most need of support (Hall, 2000).

Despite growing interest in the role of services in health improvement, wider UK health policy in the early 1990s was more focussed on the benefits of individual behaviour change than on the wider determinants of health (see for example Department of Health, 1992). The Conservative Government had reluctantly accepted the findings of the Black Report (Carlisle, 2003; Evans, 2007), limiting public dissemination of the Report to 250 copies. No policies were ever developed from its findings under the Conservative Government. The development of ABI partnerships during this period did not perhaps therefore reflect a wider policy towards addressing the causes of health inequalities but rather a more pragmatic approach to the use of government funds for the provision of mainstream services.

From 1997, ABIs formed a key part of the Labour Government's strategy to address a range of health and social issues affecting people in deprived areas. Forty three initiatives were developed centrally during Labour's three terms in office and more were funded at a local level. The spectrum of initiatives was broad, targeting, for example, education (Education Action Zones), early-years development (Sure Start), health (Health Action Zones [HAZs], Healthy Living Centres and Sport Action Zones) and economic development (New Deal for Communities [NDC]). The processes that shaped Labour's reinvigorated interest in ABIs are described and explained below.

ABIs were closely linked to the health inequalities agenda under Labour's public health policy. HAZs, Healthy Living Centres and the NDC were identified as key tools for addressing inequalities in the new government's first health Green Paper Reducing Health Inequalities (Department of Health, 1999a). The importance of

these initiatives to the health inequalities agenda was reiterated in subsequent policy and related documents over the next few years (Department of Health, 1999b, 2003, 2004). These initiatives were intended to address what were identified as key priorities: “improving the health of the worst off” (Department of Health, 1999b, p. para. 1.15) and narrowing the gap in health outcomes between the country’s richest and poorest people (Office of the Deputy Prime Minister, 2005).Interest in health inequalities can be better understood by considering Labour’s broader political objectives and the political climate in which these were developed. Labour’s approach to inequalities emerged from the central idea underpinning ‘New Labour’ politics: a “third way” between the political Left and Right (Blair, 1998). This concept was used to present the Party’s ideas as distinct from both Conservative neo-liberalism and ‘Old Labour’ social democracy, purportedly navigating a path between the individualism of free markets and the dependency of some groups on a large welfare state (Powell, 2000). The third way was associated with the idea of community as a relationship between citizens rather than between citizens and the state (Crawshaw, Bunton, & Gillen, 2003) emphasising civic responsibility as well as rights (Giddens, 1998; Powell & Moon, 2001) in the pursuit of a “fairer society” (Department of Health, 1999a, p. 5).

According to the Government’s rhetoric, health inequalities conflicted with Labour’s conceptualisation of a fairer society (Department of Health, 1999a) but as others have argued, redressing income inequality was not high on the agenda of the Labour Government (Joseph Rowntree Foundation, 2005; Stewart & Hills, 2005). In an interview for the Newsnight programme, Blair memorably remarked that it was “not a burning ambition for [him] to make sure that David Beckham [and other high earners] earn[ed] less money” (BBC News, June 4, 2001). Although Labour’s taxation policies were generally considered to be progressive (see for example Stewart & Hills, 2005), policy emphasis was placed on equality of opportunity rather than economic equality. Facilitating access to education and training were to play a large role in this as reflected in the party’s largest welfare reform, the welfare to work policy (Department for Social Security, 1998).

In many respects, Labour’s policy in relation to health inequalities represented a departure from Conservative thinking. Use of the term ‘health inequalities’ was itself in contrast to the Conservative Government’s preference for the term ”health variations” (Department of Health, 1995, p. 1) and, in the early years of Labour’s leadership, this signalled to some commentators (see for example Scott-Samuel,

2000) a departure from Conservative ideology regarding inequalities. Indeed, the development of national targets, in the first four years of government, to reduce the gap in life expectancy and child mortality rates between the most deprived local authority areas and the rest of the country was unprecedented (Department of Health, 1999a). Addressing health inequalities was also shaped, however, by on-going concerns in government about what were perceived to be unsustainable welfare costs, (Department of Health, 1999b). The rising cost of healthcare was of particular concern to the Labour Government like many other European governments at this time (Hunter, 2008), partly due to increasing demand on NHS services from an ageing population (Gray, 2007). A shift in health policy towards health promotion was intended to reduce demand on the NHS. The party's strategy for health, *Saving Lives: Our Healthier Nation*, set out plans to "reorient the NHS to ensure … health improvement will be integrated into the delivery of healthcare" (Department of Health, 1999b, p. x). A review of healthcare spending in 2001 (Wanless, 2002) supported the need to re-orientate the NHS towards health promotion. Later policy reflected the political difficulties associated with moving health policy away from treatment and towards health promotion (Department of Health, 2004) but the financial costs incurred to the UK government through health inequalities were a visible influence on Labour's early policy towards deprived areas (Department of Health, 2003).

2.3.2 Defining the causes of health inequalities: 'social exclusion'

ABIs developed under Labour were shaped by the Government's interest in 'social exclusion,' a central plank in third way politics. The Social Exclusion Unit, formed in 1997, was presented as "one of the most important new initiatives of [the] administration … [whose] purpose [was] central to the values and ambitions of the new Government" (Blair, 1997, p. 1). A concise definition of social exclusion at policy level remained elusive. It was described in the Government's action plan for neighbourhood renewal as "a short-hand for what can happen when people or areas suffer from a combination of linked problems such as unemployment, low incomes, poor housing, high crime environment, bad health and family breakdown" (Social Exclusion Unit, 2001, p. 10). In this respect, the problems identified in deprived areas were seen as being about "more than poverty and unemployment" (Mandelson, 1997, p. 1). Reflecting third way thinking, the origins of the problems in deprived areas were located in the relations between citizens, their social exclusion and limited participation in services, and not wider societal structures.

Government attention was focussed on a social disconnection between people experiencing these problems and the rest of society, people whom policy makers (Mandelson, 1997, p. 1) described as being “cut off” from mainstream society and so the origins of social exclusion were firmly located in deprived areas. The targets of social exclusion policy were neighbourhoods and estates where these problems were considered to be entrenched and the purpose of ABIs was to ensure that “no-one is seriously disadvantaged by where they live” (Social Exclusion Unit, 2001, p. 5). Use of the term ‘exclusion suggests that some groups and people are “shut out” from society (Micklewright, 2002, p. 3) but policy directed little attention towards the processes that disempower and ‘exclude’ some people in society The focus of ABIs was relations between residents living in deprived areas, rather than their relations with others in less deprived areas.

The interpretation of social problems that this concept encourages is also limited by the dichotomous mode of thinking it promotes in terms of viewing people as either ‘excluded’ or ‘included’. Though the complexity of the processes preceding exclusion were acknowledged in policy at the time, this dichotomy was related to a search for the ‘causes’ of social exclusion. Long-term unemployment and low public involvement with public services were identified as part of a number of interrelated causes of the problems observed in deprived areas (Social Exclusion Unit, 2001, p. 12). Through a discourse analysis of Labour’s social exclusion policy, Macleay (2008) identified Labour’s welfare to work policy and its focus on ‘civic engagement’ as key components of a new form of neo-liberal governance which focussed policy attention on individual responsibility within a free market system. In this respect, the ABIs can be seen as a means through which people living in deprived areas were targeted for their apparent inability to take advantage of economic and social opportunities. This interpretation is illustrated by a statement given by the Minister for Social Exclusion, 10 years into the Labour leadership who suggested that “a stable economy with investment and reform of public services has provided opportunities” but that more work was needed to help “the most disadvantaged … to get themselves out of their difficulties and to gain control of their lives” (Social Exclusion Taskforce, 2007, p. 5). In this respect, Labour’s ABIs reflected over a hundred years of policy that located the solutions to the problems observed in deprived areas within the localities in which such problems manifested rather than in the relationships between different groups at a local, national and global level.

Part of the rationale for using ABIs to address social exclusion was to target support to the most disadvantaged people in the country (Social Exclusion Taskforce, 2007). Policy documents also drew attention to the different experiences of poor people living in more and less deprived areas, proposing that the former posed a more significant problem (Social Exclusion Unit, 2001). It was understood that people in deprived areas could be even more cut off from services and employment opportunities. Not all deprived areas have been reached through this policy however, partly as a result of competitive bidding processes. For example, as Lawless (2011) has noted, out of the thousands of neighbourhoods that the Government had identified as socially excluded, only 39 neighbourhoods were granted NDC funding. In addition, as already discussed, there is debate as to whether an area approach is the most effective means of reaching the largest number of people living in deprived circumstances given that large numbers of disadvantaged people live outside of these areas.

2.3.3 Contact with service providers as a means for improving health

As part of many ABIs, local services were given a key role in addressing social exclusion. It was suggested that contact with services was a means through which social exclusion (Blair, 1997) and consequently health (Department of Health, 2003) could be improved. Labour suggested that services in deprived areas were under pressure because these services were in more demand and that, as a result, "the poorest areas have often received the poorest public services" (Social Exclusion Unit, 2001, p. 19). Conversely, there was also a perception that service providers in deprived areas were ineffective in reaching people who might benefit most from their help (Department of Health, 2003). ABIs were described as an opportunity to improve health in these areas through improvements in the quality of public services and in the quality of "social and material resources" (Department of Health, 2001, p. 24). These initiatives were intended to supplement mainstream provision, providing innovative ideas that would "respond to the diversity of need" in deprived areas (Department of Health, 2003, p. 10). Initiatives were generally funded for a fixed time period in anticipation that mainstream provision would be influenced as a consequence of the initiative. Although there is support among researchers for targeting resources at the most deprived areas as a means of encouraging fairer access to services (see for example Dorling, 2010), the life span of many Labour ABIs has come under criticism for being too short to demonstrate impact and hence influence changes in mainstream provision (see for example Cox & Schmuecker, 2010).

Central to the rationale for the use of ABIs was an aspiration for health improvement services to be delivered “through local organisations”, which was closely related to VCS involvement in the delivery of services (Department of Health, 1999b, p. 5). In 2002 Labour set out a target to increase the involvement of the ‘third sector’ in public services by 5% (House of Commons Public Administration Select Committee, 2008). The term ‘third sector’ was coined by the Labour Government to include “non-governmental organisations that are value driven and which principally reinvest their surpluses to further social, environmental or cultural objectives” (Communities and Local Government, n.d.), but its use has come under criticism for proposing a hierarchical relationship between sectors (O'Corry, 2010). Although measurement of the above mentioned target was abandoned, involvement of the VCS in the delivery of public services did grow rapidly under Labour (Alcock, Brannelly, & Ross, 2004). At the start of the millennium, it was estimated that government provided 30% of all funding (£3.7 billion) for UK charities (HM Treasury, 2002). By 2010, funding for the sector from statutory contracts alone had reached £9.1 billion (National Council for Voluntary Organisations, 2010).

Labour identified the VCS as having a “strong focus on the needs of service users” and “the capacity to build users’ trust” (H M Treausry, 2004, p. 23). The Government also described the VCS as “much better than the statutory sector at engaging with groups of people who face most difficulties or who do not access traditional sources of advice on health” (Department of Health, 2004, p. 79). In part, this view has been attributed to perceptions that VCS providers have better expertise and knowledge in relation to specific groups of people and, consequently, are anticipated to be better able to meet service-users’ needs (House of Commons Public Administration Select Committee, 2008). Several reasons for this have been identified including first-hand experience of the issues with which they are dealing among some staff (Anderson & Heritage, 1996), the role afforded to service users in VCS operating structures (through service-user representation on governing bodies, for example), the community base of many VCS organisations, (House of Commons Public Administration Select Committee, 2008) and the apparent independence of the sector from government (Billis & Glennerster, 1998) and profit making share-holders (Halfpenny & Reid, 2002).

The Labour Government’s interest in VCS provision of public services reflects longer-term processes of welfare reform in UK policy. Charitable organisations have

a long history of welfare provision in the UK. As the state took on increased responsibility for the provision of welfare services after the Second World War, debate emerged as to whether the VCS should seek to provide an alternative to state provision, in competition with state services, or to provide complementary services that met the gaps within state provision (Alcock, et al., 2004). The latter approach prevailed during this period, as the state provided funding for VCS activities through the awarding of grants. The expansion of laissez faire ideology during the latter half of the twentieth century signalled a changing role for the sector however. Neo-liberal policies of the Conservative era from 1979-1997 encouraged reduced state intervention in welfare, promoting a large role for the VCS in supporting the needs of those people unable to meet their needs in the market (Halfpenny & Reid, 2002). Labour continued to commission VCS organisations to deliver welfare services (Alcock, et al., 2004) encouraging for the first time their involvement in health services (Department of Health, 2000). Continued policy interest in VCS provision reflected on-going concerns about funding the welfare state and healthcare services in particular. Heins, Price, Pollock and Miller (2010) have argued that VCS participation in competitive commissioning processes was encouraged to balance the anticipated cost-cutting benefits of market competition with the involvement of organisations apparently more focussed on patient interests than profit-driven organisations. In this respect, interest in the VCS can be better understood as a key strand of Labour's third way of governance.

Despite this interest, there is limited empirical research exploring policy claims that VCS providers are better equipped to attract and work with groups of people traditionally considered to be hard to reach by other service providers (House of Commons Public Administration Select Committee, 2008). The experiences of VCS involvement in ABIs will be explored in more detail in the following chapter but it is worth noting here that identifying similarities across the sector in order to interrogate policy claims is particularly challenging given its diversity. Halfpenny and Reid (2002) warn against rigid definitions of the sector that fail to acknowledge the overlap with private and public sector organisations or the extent to which organisations within any defined category might differ. The VCS encompasses a variety of organisations with a range of different origins, goals and working practices, making comparisons across the sector problematic.

2.3.4 Improving services through partnership

As has been noted elsewhere (Perkins, et al., 2010), service provider partnerships have a long history in UK policy, particularly in health and social care, but the idea of co-ordinated working at a local level gained increased momentum from 1997 and was extended to the arena of public health, with the potential involvement of a range of different organisations. As Carlisle (2010) highlights, partnership arrangements with a range of providers became a requirement for government funding for some mainstream statutory services (see for example Department of Health, 2000). Co-ordination of services at a local level was encouraged through a variety of other means. Health Improvement Programmes, for example, were underwritten by law in the Health Act of 1999, which required newly created PCTs and local authorities to work together to implement a health improvement agenda (Baggott, 2000). In addition to mainstream activity, ABIs were designed to better co-ordinate service providers in deprived areas in particular. Co-ordination of local services was a core feature of a number of initiatives including HAZs, Sure Start and NDCs. Service provider partnerships set up as part of ABIs took many different forms. They typically involved statutory, VCS and in some instances, private sector providers.

Renewed interest in service partnerships can be better understood with reference to government concerns about funding the welfare state and the cost of healthcare more particularly. It was proposed that an "inability to forge effective partnerships with local government, business and community organisations [had] inhibited the NHS's ability to prevent ill health and tackle health inequalities" (Department of Health, 2000, p. 23). It was suggested that the health of people living in deprived areas could be improved through better co-ordination of cross-sector services (Department for Communities and Local Government, 2006; Department of Health, 2001, 2004; National Institute for Health and Clinical Excellence, 2008). Part of the explanation was economic. It was anticipated that the poorer quality of public services observed in deprived places (Dorling, 2010) could be addressed if "resources [were more] effectively shared" between local service providers (Department of Health, 1997).

Building on the ideas that had underpinned the SRBs initiated by the previous Conservative Government, the rationale for service co-ordination was also based on a perceived interrelationship between problems in deprived areas. The Prime Minister (Blair, 1997, p. 3) proposed that "joined up problems demand joined up solutions." There was a perception within the Government that co-ordinated

solutions at a local level could be developed using the combined expertise of a range of providers (Blair, 1997). HAZs, for example, were intended to facilitate synergy between the work of different local agencies in addressing a range of health and social problems (Health Development Agency, 2004). As Bauld et al. (2005) highlight, HAZs were intended to create opportunities for innovation in service delivery by encouraging providers to work outside of their professional boundaries.

This renewed interest in partnerships can also be better understood with reference to Labour's interest in third way politics and its attempts to steer a course between government intervention and individual action. The participation of local organisations and local residents in social policy has been described as means of governance at arms-length (MacLeavy, 2008) reflecting Labour rhetoric that " each citizen is valued and … no-one is excluded from opportunity and the chance to develop their potential" (Blair, 1997, p. 2) but that people had a moral responsibility to take any opportunities created for their own health (Department of Health, 2004). There was an expectation in policy documents that better co-ordination of services might influence "fairer access to services and a reversal of the 'inverse care law" (Department of Health, 2003, p. 12). Co-ordinating provision across different sectors was therefore associated with encouraging participation in services among residents in deprived areas in order that they might take increased responsibility for their own lives and wellbeing. The notion that residents might develop social capital through this participation was central to Labour ideals of communitarianism (Campbell, Wood, & Kelly, 1999). Drawing heavily on Putnam's (2000) ideas about the potential benefits to communities through civic engagement, the Government was keen to explore, through the work of the Health Education Authority and later the Health Development Agency, how "social capital could serve as a framework for the design and evaluation of community level health promotional interventions and policies and for research into the health-community interface" (Swann & Morgan, 2002).

2.3.5 An emphasis on evaluation

A key mantra in Labour policy after 1997 was a commitment to developing evidenced-based policy and supporting "what works" (The Labour Party, 1997). This influenced a drive towards evaluation of policies, interventions and services. This interest reflected a growing research trend for evaluation of social interventions with

the development of evaluation methods but also a political statement of reform. As Pawson and Tilley (1997, p. 12) note, a commitment to evaluation represents "a political statement" of commitment to solving 'social problems'". The use of 'evidence' in the policy making process is a complex issue that is of growing interest in a range of policy areas including sport (Bloyce & Smith, 2010), welfare (Boa, Johnson, & King, 2010) and health (Black, 2001; Buse, Mays, & Walt, 2005; Waddington, 2000), and there is debate regarding the extent to which it is feasible or even desirable to develop policy according to 'evidence'. Nevertheless, ABIs developed under the Labour Government were influenced by this drive for evaluation as expectations were raised that only 'successful' interventions would be re-commissioned. The ways in which the drive for evaluation shaped initiatives is discussed in the following chapter. The section below describes the initiative examined in this study, which encapsulated many aspects of Labour's policy towards deprived areas.

2.4 Target Wellbeing: a case study of an area-based initiative

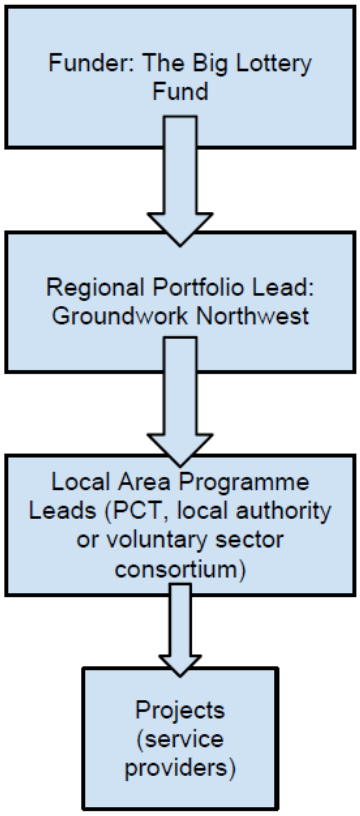
In 2006, the BIG Lottery launched its 'Well-being Fund' to finance regional programmes of activities designed to improve the health of the local populations. BIG allocated £45 million to organisations across England to "deliver a portfolio of projects to support the development of healthier lifestyles and to improve wellbeing" (BIG Lottery Fund, 2006b, p. 3). Led by a team of people from a social enterprise company called Groundwork Northwest, a group of VCS and public sector workers came together to write a bid for a programme of activities across the north west of England, which they called 'Target Wellbeing'. The group that came together was called the Northwest Wellbeing Partnership. In the development of its bid, the Partnership drew on analysis conducted by the North West Public Health Observatory (NWPHO) to identify geographical areas of 'disadvantage' at which to target funding (Wood et al., 2006). Disadvantage was defined in terms of levels of health and wellbeing as measured by self-rated physical and mental health, obesity rates, fruit and vegetable consumption, incidence of coronary heart disease and benefit claims (Northwest Wellbeing Partnership, personal communication, 2006). The 10 local authority areas shown to have the highest proportion of residents with the worst health outcomes using these measures were selected for inclusion in the consortium's bid (Northwest Wellbeing Partnership, personal communication, February 21, 2007). The 10 areas targeted were Halton, Pendle, St Helens, Oldham, Knowsley, Burnley, Ellesmere Port , Liverpool, Manchester and Preston. In

this respect, TW reflected a trend in health policy for targeting people considered to be in most need of support from services as a means of addressing poor health in these areas (Northwest Wellbeing Partnership, personal communication, February 21, 2007). However, the targeting of particular wards within these areas distinguished TW from some earlier national ABIs. Targeting funding at concentrated populations provided an opportunity to test the impact of service intervention at a very local level. An organisation in each of the identified geographical areas was contacted by the TW Partnership and asked to lead a bid for a programme of activities in their area. In most instances this organisation was a PCT or local authority but in one area it was a VCS organisation.

Reflecting Labour policy, BIG Lottery guidance (2006a, p. 3) to funding applicants stipulated that programme activity should place particular emphasis on "promoting partnership working between organisations within the health sector and across other sectors to increase participation and innovation and encourage a joined up approach" to project delivery. The guidance also stated that programmes should be co-ordinated at a regional level (BIG Lottery Fund, 2006b). To facilitate this, an organisational structure was developed by the Partnership to manage and deliver the area-based programmes of activities. The Partnership bid was successful in gaining funding for 10 area-based programmes. The funding and related reporting structure is illustrated in Figure 2.2.

Also reflecting national policy interests, there was an expectation within the Partnership that VCS organisations would be funded to develop activities for the programme (Northwest Wellbeing Partnership, personal communication, February 21, 2007). It was reported in the Ellesmere Port bid document that involvement of the VCS in the design of activities would ensure that such activities reflected the needs and interests of local residents (Ellesmere Port co-ordinators, personal communication, February 2007). Consequently, there was an expectation that local residents would be more likely to participate in activities and services from which their health might benefit. Roughly 85% of the organisations funded to deliver TW activities were from the VCS (Northwest Wellbeing Partnership, personal communication, February 21, 2007). The large proportion of VCS organisations and the leadership role of Groundwork Northwest presented an opportunity to explore the role that the VCS could play in ABIs for health improvement.

Figure 2.2 Target Wellbeing funding structure



Current policy trends suggest that localised public health action will remain on the political agenda. Although the current Coalition Government has signalled that there will be fewer government-funded health initiatives, interest in local co-ordination of services, and a role for the VCS in facilitating "local innovation" for health improvement, has remained (Department of Health, 2010b, p. 3). Following the financial crisis of 2007, saving money from healthcare has become an increasing concern and the first Coalition Health Secretary called for a rebalance of the health system to focus on public health (Lansley, 2010, July 7). This suggests that the current Government will continue to explore ways in which social interventions delivered at a local level might be used to save healthcare funding. There is also likely to be continued interest in using the VCS to encourage the participation of residents in deprived areas in services and activities that might improve social cohesion (Cabinet Office, 2010). This suggests that the issues explored in this thesis will be of relevance to understanding implementation of public health policy through localised programmes.

2.5 Conclusions

This review has identified a number of consistent features of ABIs in English public health policy over time. ABIs have generally constituted interventions which are time-limited, delivered within geographical boundaries and focussed solely on processes in deprived areas, providing something additional to mainstream services, performing a variety of functions simultaneously and involving a wide range of organisations, groups and people. Activity has focussed on changing the physical environment, stimulating the local economy and, more recently, addressing 'social exclusion'. Conceptualisation of the problems in deprived areas has often focussed on the people within those areas in isolation from wider society.

Three interconnected themes were identified in recent policy targeted at deprived areas: utilisation of VCS organisations to deliver services, co-ordination of local services, and participation of local people with these services. The ways in which these issues have been explored within empirical research and theoretical research into ABIs will be examined in the following chapter.

Chapter 3

Understanding area-based initiatives

3.1 Introduction

The purpose of the chapter is to examine the ways in which ABIs have been interpreted to date in the academic literature. Empirical and theoretical studies are reviewed in order to describe and assess the adequacy of existing knowledge about how ABIs develop. Although the literature review process in this study was conducted in tandem with the process of data generation, the findings from the review are presented at this point in the thesis in order to contextualise the rest of the study (Dunne, 2011). The role of literature in the development of the study is discussed in more detail in Chapter 5. The chapter considers what is known about the ways in which ABI partnerships develop before moving on to discuss what is known about relations between residents and providers. The final part of the chapter is devoted to reviewing the ways in which consequences of ABIs have been understood.

3.2 Service provider relations in area-based initiatives

As discussed in the previous chapter, certain consequences have been anticipated from ABI partnerships at a policy level, in terms of provider co-operation and collaboration. Indeed, much of the academic work that explores service provision partnerships starts from the premise that partnerships might be defined as co-operative relationships. A review of the literature on health partnerships by Wildridge, Childs, Cawthra and Madge (2004, p. 21) identified several core concepts in different definitions of partnerships; these included “common … aims, vision, goals, mission or interests” among two or more organisations as well as sharing “joint rights, resources and responsibilities.” Despite sustained policy interest in ABI partnerships, research indicates that they have not been implemented according to the expectations of policy makers (Berkeley & Springett, 2006) and that co-ordinated working between providers in ABIs has been limited (Hunter & Perkins 2012). These findings have influenced a substantial amount of research into how collaboration might be improved (Lester et al., 2008; Perkins, et al., 2010; Wildridge, et al., 2004). The research problem in relation to ABI

partnerships has often, therefore, been framed as one of implementation, beginning from the premise that partnerships are easily defined and intrinsically valuable to targeted communities. The literature on partnerships is extensive. The focus of this review is ABI partnerships and the ways in which they have been conceptualised in order to explore why unexpected consequences have emerged from attempts to develop co-ordinated working in ABIs.

The role of individual action in service provider partnerships often remains hidden in the research literature, which focuses instead on identifying social structures and events that influence partnership as if they were independent of, rather than constituted through people. For example, differences in the governance structures of organisations across different sectors was identified as a barrier to VCS involvement in the strategic development of HAZs (Unwin & Westland, 2000), but few attempts have been made to understand the ways in which governance structures are maintained or challenged through individual action in an ABI partnership. There is evidence to suggest that providers' personal dispositions shape the ways in which partnerships unfold. In their evaluation of a community housing scheme (which sought to co-ordinate at an area level the work of housing services, healthcare providers and social care workers) Cameron, Lloyd, Turner and Macdonald (2009, p. 392) found that there was friction between staff in different organisations working at an "operational level." The authors attribute the tensions to entrenched views that these front-line providers held about people in other professions but found that providers working in more strategic roles were more supportive of collaborative working. Without examining the ways in which such dispositions are developed, their impact on partnership development cannot be fully understood. Other research indicates that emotions play a part in the development of these dispositions, which has a strong influence on partnership development. Lester et al. (2008, p. 497) found that VCS providers' willingness to work in collaboration with healthcare professionals in an area-based mental health initiative was mediated by a fear that their "independent" image among users might be damaged. In her study of an area-based partnership between children's service providers Milbourne (2009, p. 291) concluded that "collaborative work often depends heavily on the commitment, dispositions and networks of people." However, by using a cross-sectional design that prohibits examination of the ways in which such commitments, dispositions and networks are formed over time, Milbourne is unable to explain why such processes influence partnership development.

Several studies have also shown that competition for ABI funding between service providers, encouraged through national policy, can undermine capacity for collaborative working (Carlisle, 2010; Milbourne, 2009). Understanding the ways in which competition is experienced by people will illuminate the way in which it influences partnership development. There is an indication that competitive processes influence people to behave in particular ways. Milbourne (2009, p. 287), for example, found that competitive bidding processes influenced "fear of outsiders" among service providers. Again, although such work is important in identifying problems that influence partnership development, it fails to explain how competition shapes particular consequences, making it difficult to know which aspects of competitive processes, and under what circumstances, might be damaging to collaborative working. Without an understanding of the social context in which provider relations develop, individual actions cannot be accounted for. Understanding how fear of outsiders might be developed and how that fear drives individual behaviour will be key to understanding how partnerships develop.

The social context in which partnerships develop has often, inadequately, been identified as distinct from the people who influence it. Research designed to measure partnership "functioning" has been criticised (Ansari & Weiss, 2006, p. 176) for failing to distinguish between "individual-level phenomena" (defined as individual characteristics) and "partnership level" phenomena (defined as group characteristics). This criticism overlooks the relational nature of partnerships, which exist only through connections between people. The attempt to measure partnership functioning also reveals an assumption that the consequences of partnership development can be anticipated and measured. Research has so far indicated that predicting the outcomes of ABI partnerships is an impossibility (Berkeley & Springett, 2006).

The separation of context and individual actions has influenced a focus on identifying "factors" that influence partnership development (Wildridge, et al., 2004, p. 6) or, as Dowling et al. (2004) have argued, on the identification of barriers to implementing planned action (see for example Beatty, Foden, Lawless, & Wilson, 2010; Lester, et al., 2008). It could be argued that this encourages a shopping basket approach to identifying the ingredients of 'successful' partnerships with little reference to the social context in which such partnerships develop. This has also been the case for ABI partnerships. Checkland et al. (2009) suggest that more

attention on the social conditions that create perceived barriers to partnership development is required.

Pawson and Tilley's (1997, p. 70) realist view that interventions are "introduced … into an existing set of social relationships" draws attention to the fact that partnerships develop out of existing relations. Studies have shown that ABI partnerships are influenced by the history of relations between providers in an area. Dinham (2005, p. 307), for example, found that a "history of rivalry for voluntary sector funding" influenced the way in which relations in NDC partnerships developed. Harris and Young (2010, p. 50) found that people who had a history of working towards a particular issue in a local area were viewed as having a "commitment" in the eyes of community leaders which facilitated trust when working with others. Drawing on ideas from new institutional theory, Barnes, Matka and Sullivan (2003, pp. 289-290) argue that "logics of appropriateness" (or organisational norms), formal rules within organisations and "historical institutionalism" (or the origins of an organisation) will influence the decisions that providers make when working in partnership. These ideas are helpful in focussing attention on the history of relations in particular organisations. Further research is required, however, to explain how organisational history manifests in the behaviour of people.

Understanding the history of relations is, therefore, important, but it is also worth noting that relations change over time. There has been a tendency in realistic evaluations of ABIs to view relations as static, as others have argued (Barnes, et al., 2003). This is exacerbated by the fact that many ABI studies have adopted a cross-sectional study design which precludes the examination of joint working as an emergent and developmental social process. As a consequence, partnership processes are often depicted as linear and predictable (see for example Boydell & Rugkåsa, 2007; Lawless, 2002) which fails to account for the complex set of dynamic social relations that will influence their development. Other models also view partnerships as static. Asthana et al. (2002) identified a framework for evaluating ABIs that they used to describe what took place within an HAZ, distinguishing between context, inputs, processes, outcomes and impacts. This framework, however, lacks explanation about the connections between these elements and neglecting the fact that each aspect represents a social process, influenced by the development of relations between people.

The influence of dynamic social relations on the development of partnerships has not been adequately accounted for thus far. Research indicates that relations between people involved in the partnership and their relations with others outside of it influence its development. As Sullivan et al. (2006) note, researchers have struggled to explain how partnerships are influenced by unplanned events 'outside' of the partnership. For example, tension between national and local policy has been identified as a problem in ABI partnerships (Beatty, et al., 2010). The reification of both 'partnerships' and 'social context' has influenced a tendency to explore the local context in isolation from the national context in which partnerships develop. For example, there has been criticism that ABIs have been difficult to integrate with existing services and with other initiatives locally (Hunter, 2007) and recognition that national policy sometimes contradicts the aims of ABIs (Office of the Deputy Prime Minister, 2005). Lawless (2006, p. 1991) describes these influences on ABIs as "barriers operating at the neighbourhood, city-wide and national levels," distinctions that have been maintained in the work of others (Thomson, 2008b). Such 'barriers' might more adequately be conceptualised as interconnected social processes as research indicates that the actions of ABI providers are constrained by their dependency on national policy makers. For example, interviews with NDC providers and stakeholders as part of the national evaluation (Lawless, 2004) showed that social service staff found it difficult to shift their work to look at area-level issues, partly as a result of national targets set for individual organisations. Central targets have been shown to take priority over ABI objectives in other studies (Ainscow, Dyson, Goldrick, Kerr, & Miles, 2008). These examples show how local activity is constrained, but not stopped, by processes instigated through central government.

Power within ABI partnerships has so far been conceptualised as a static attribute of particular groups. For example, there has been a tendency to assume that VCS providers have less power and influence than statutory providers in ABI partnerships (Unwin & Westland, 2000). Statutory providers are often depicted as having "particular mandates or powers" which enable them to influence local conditions that shape people's lives, while VCS providers are seen as having expertise in dealing with particular groups, the effects of which on the power balances in partnerships are rarely considered (Andrews & Entwistle, 2010, p. 680). Research indicates that although VCS providers are often dependent on statutory partners for funding, they have power to influence the partnership in other ways. For example, Chapman, Brown, Ford and Baxter (2010, p. 618) found that VCS providers were often "combative" in their relations with statutory providers in local initiatives which

thwarted collaborative working. Some studies have adopted a more nuanced understanding of VCS organisations and shown that different types of organisations have different influence over collaboration. Harris and Young (2010) found that small VCS providers were reliant on bigger VCS organisations for resources which influenced confusion about governance and accountability in the delivery of ABI activities.

Few studies have captured the way in which power balances between organisations can change over time. It has been shown that the characteristics of providers are not static, and that in different circumstances, providers in specific sectors behave differently. In a review of the literature on VCS involvement in the delivery of health services, Heins, Price, Pollock and Miller (2010) showed that under the conditions of competition for delivery in healthcare, non-profit organisations were less concerned about value-driven work and more concerned about profit. Halfpenny and Reid (2002) argue that power imbalances between providers are not resolved through intentions of joint working. They suggest that power struggles over resources will influence the way in which partnerships develop. It seems necessary, therefore, to explore how power imbalances develop and the ways in which such imbalances influence partnership development.

The problems with partnerships described above indicate that there is no straightforward causal relationship between strategic aspirations, planned activity and outcomes and that there is limited understanding of the links between the complex, dynamic social processes that shape service providers relations. In summary, there is limited sociological explanation for why partnerships have not developed as expected. There are calls (Ansari & Weiss, 2006) for more research that explores the context in which partnerships operate in order to make findings generalizable to others working in different fields. In particular, there has been a failure to account for the historical context of geographical groups when implementing and researching what takes place in ABI partnerships. The role of individual action, and the ways this is influenced by emotion, as well as the influence of different types of power seem to be important in developing a more adequate understanding about how ABI partnerships develop.

3.3 Relations between area-based initiative providers and targeted residents

This section of the chapter considers the ways in which relations between service providers and residents targeted by an ABI have been described and explained.

The idea of social exclusion is critically examined as well as the ways in which ABIs have been perceived to address this problem through 'engagement' of residents in services.

3.3.1 Conceptualising area-based communities

As shown in the previous chapter, a fundamental idea underpinning ABIs was that people living in geographical areas of high deprivation have similar needs that can be met through the provision of area-based services. By changing something about the place in which people live, in the case of Labour ABIs, through the organisation of services, it was intended that ABIs would improve the lives of the people living there. ABIs have therefore been based on an assumption that the administrative boundaries within which they are delivered have meaning for the people who inhabit them. The ability to target the most deprived people by targeting areas with high levels of aggregated deprivation has been questioned given that not all people living in a defined geographical area will experience this deprivation in the same way (Thomson, 2008a). Empirical studies have shown that the groups and people targeted by ABIs do not always share common identities or values (Campbell & Murray, 2004). Carlisle (2010), for example, found that rivalries existed between people in the same neighbourhoods targeted by Social Inclusion Partnerships across Scotland. Similarly, researching regeneration projects targeted at small housing estates, Hothi, Woodcraft, Cordes and Muskett (2010) found variations across neighbouring streets in the way that residents defined their local community.

As Cummins, Curtis Diez-Roux and Macintyre (2007) note, theoretical insight into the meaning of 'place' has been advanced in recent years by the work of social geographers who have emphasised the importance of social relations over spatial dimensions in understanding place. Massey, (2005, p. 9) for example, has conceptualised place as a dynamic "product of human relations". Administrative boundaries therefore partly reflect social interaction (Cummins, et al., 2007) but as relations between people are never confined to single geographical areas, such boundaries reflect only a small part of the experience of the people within them. As people move in and out of different physical spaces, they influence and are influenced by a range of different contexts (Cummins, et al., 2007). This challenges the idea that the characteristics of people and the social context in which they live can be separated. Bernard et al. (2007) argue that it is more adequate to describe the social context in which people live and their compositional attributes as being in

a dialectical relationship. However, this conceptualisation maintains a distinction between the people and the 'place' that they create.

If place is considered to vary "in time and space" (Cummins, et al., 2007, p. 1835) it is possible that the concept might mean something different among different groups at different times. This suggests that the routes to ill health and social problems in deprived areas might vary for different groups and people. Collective stories go some way towards shaping how place is understood. In their study of socio-economically deprived neighbourhoods in northern England, Cox and Schmuecker (2010, p. 7) found that the "story of place", or the ways in which local events are understood and talked about collectively by local people, had an impact on the image of the area. This reflects Anderson's (2006, p. 7) ideas about communities as "imagined" spaces constructed through narratives that change over time.

Another consequence of defining place in fluid and relational terms for the study of ABIs is that relations with people in neighbouring areas might be of relevance to understanding the experiences of targeted residents. Connections to nearby places are important as capital, culture and people flow between places (Cummins, et al., 2007). Humphreys (2007, p. 62) argues that residents' connections to the places they inhabit are influenced by the "history and cultural assets of place, perceptions of common situational circumstances … and external perceptions of place".

3.3.2 Understanding processes that exclude residents from services and employment

Social exclusion from employment opportunities and services is commonly used to define the problems in areas targeted by ABIs. There are some advantages of defining the problems in this way in terms of developing understanding. The idea of social exclusion focuses attention on the relational dimensions of socio-economic deprivation and poor health. The social dimensions of deprivation have emerged as important in a number of ABI studies. For example, Cox and Schmuecker (2010, p. 5) found that people living in deprived areas had "shorter travel horizons" than people in less-deprived areas in terms of their willingness to move beyond certain geographical areas to access employment opportunities and services. While restrictions on travel might be imposed by affordability of travel to place of work and associated costs of childcare (Green & White, 2007), service providers interviewed by Cox and Schmuecker (2010, p. 63) identified the way in which residents related

to others in neighbouring areas as a key part of the explanation, describing residents as having an “island mentality,” which made them distrustful of services and opportunities outside of the area.

One of the criticisms of an emphasis on social exclusion as a concept for understanding residents’ experiences is that attention is diverted from the influence of national and global processes. The separation of processes operating at a national level from those operating in local areas is unhelpful: as Popay, Williams, Thomas and Gatrell (1998, p. 632) have argued, “‘place’ [is] the primary site for the impact of macro social structures to be played out in the daily lives of people.” This suggests that in order to understand the social context in which ABIs have been implemented, processes at several different geographical scales need to be considered. This point is made apparent by research that shows how large-scale processes, involving large numbers of people across the globe, are experienced in deprived areas. Research has shown that work opportunities in particular areas are often constrained by strategic decisions made at a national level. The practicalities of commuting long distances and the financial cost and social upheaval of relocating for employment mean that labour markets are generally subdivided by geography (Green & White, 2007). This influences the context in which people make decisions about employment locally. Despite a general trend towards geographical mobility in terms of work, less-skilled workers are more constrained in employment options by where they live, partly as a result of lower incomes (Green & Owen, 2006). Research comparing economic improvement across deprived areas prior to the 2007 recession (Cox & Schmuecker, 2010) demonstrated that the proximity of entry-level jobs to deprived areas impacted on the number of people claiming work benefits there. Reduced job opportunities have also been shown to influence the way in which people living in socio-economically deprived areas respond to others. The closure of large employers in former mining towns in the north of England following large-scale economic changes has been shown to influence a legacy of distrust towards people from outside of the area and service providers in particular (Cox & Schmuecker, 2010). Research by Hothi et al. (2010) demonstrated how feelings of neglect can emerge following the gradual disappearance of services from formerly industrious estates.

A focus on social exclusion also obscures the role of human actions in the processes that shape exclusion from services and employment. People targeted by ABIs are sometimes depicted as passive victims of processes caused by social

forces or “factors” (Sanderson, 2000, p. 131). Research shows that people living in deprived areas, although constrained in their choices, have influence over their lives. For example, research has shown that people living in similarly deprived circumstances sometimes respond very differently to their environment. Popay et al. (2003a), for example, argue that different biographies influence different strategies for dealing with economic deprivation. Stephens (2007) has also argued that people living in deprived areas develop strategies that help them to cope with their circumstances, which are shaped by individual and group identities. This research shows that, although influenced by the actions of others, people have some control over whether they use, or do not use services. Drawing on the work of Bourdieu, Stephens explains how particular identities are operationalized by residents in deprived areas in different social contexts according to calculated benefits. In her study of participation in community health services some residents perceived that there was more to be gained from an association with one’s neighbourhood in order to defend it in the face of press stigma, but that residents often identified with parents of children in particular schools outside of the area to which they aspired to send their own children. Understanding the nuances in individual circumstances that shape different behaviour is key to understanding how change might be facilitated in deprived areas.

Related to this, there is an increasing interest in the UK in research that explores how social inequality “gets under the skin” or becomes imbued in the psyche such that it shapes responses to economic deprivation (Wilkinson & Pickett, 2010, p. 31). The interweaving of social and psychological processes can influence conditioned responses. Research into the experiences of socio-economically deprived areas showed that established ways of thinking influence the ways in which residents and community leaders respond to change. Hoyt and Leroux (2007, p. 8) showed how the inability of local leaders in some deprived communities in North America “to understand and accept a new set of [economic] conditions” influenced continuing cycles of economic deprivation. The interweaving of large scale processes and individual actions needs careful attention in order to improve understanding about the processes that shape residents’ exclusion from services in deprived areas.

Emphasis on the social networks from which residents are excluded also diverts critical attention from the social networks in which residents are embedded. Residents in deprived areas have been shown to occupy dense networks (McPherson, Smith-Lovin, & Brashears, 2006). Although the pathways through

which influence is mediated are not fully understood, friends and family networks have been shown to influence a range of health-related behaviours (Christakis & Fowler, 2007; Macmillan, 2009). These networks therefore need to be considered in terms of explaining the pathways from deprivation to health outcomes in areas targeted by ABIs. Forbes and Wainwright (2001) describe the way in which processes of exclusion operating at a broader societal level influence the ways in which people relate to one another at a local level, which the authors link to the ways in which local networks might reinforce particular behaviours that are damaging to health:

> If a group of people are disbarred from the mainstream, social processes do not stop, there is still a need to interact economically, socially and politically with each other and hence the need for rules and norms to guide that interaction. That in certain circumstances these rules and norms promote risk may be related to the circumstances which enforce that adaptation. In other words, the increased violence and distrust that Wilkinson (1999b) observed in deprived communities within unequal societies is born of both the internal dynamics of that community — i.e. the need to survive 'I've got nothing so I'll take what I can'; together with the opportunities afforded to the community to participate in the mainstream and its value to society (Bourdieu et al., 1999).
>
> (Forbes & Wainwright, 2001, p. 808).

The processes through which community norms are established in relation to wider societal processes is important for understanding the influences on residents' participation in ABI activities. Reviewing the literature on social belonging, Mckenzie (2012, p. 459) has argued that residents in deprived areas "[engage] in a local system that finds value for themselves in understanding how [their] estate works". Understanding these systems can contribute knowledge about how residents make sense of participation in an ABI. The implications of these ideas for understanding ABI participation are discussed below.

3.3.3 Understanding how resident relations with providers develop over time

There is uncertainty about the extent to which ABIs have been successful in targeting the people they are intended to reach. One of the ways in which success has been measured has been to quantify the number of times residents have participated in ABI activities. Some of the groups targeted by Sure Start were defined in the national evaluation as "hard to reach" because few members of these groups participated in ABI activities (Anning, Stuart, Nicholls, Goldthorpe, & Morley,

2007, p. 122). Fathers, families from black and minority ethnic groups and working parents were all under-represented in Sure Start activities (Anning, et al., 2007). Another measure of success has been the duration for which residents have been registered for activities or the intensity of their involvement. The participation of target groups has also been disappointing according to these measures. Evaluation of the Headstart programme in the USA, on which the Sure Start model was based, showed that families scoring highly on a number of social deprivation indices were less likely than other families to remain enrolled in programme activities for over two years; they were also less likely to be rated as " highly engaged in the program" by programme providers (Love, Kisker, Ross, & Schochet, 2002, p. 398). In the UK, black and minority ethnic groups were under-represented in NDC community partnerships which required long-term commitment from residents (Lawless, 2004). Provider perceptions have also been used to describe the characteristics of people participating in ABI activities. Based on these measures, there is also some indication that ABI providers often engage groups who are already participating in services. For example, in a study of a small community intervention, Harris and Young (2010) found that organisations often recruited residents to activities who already had an established involvement in community-development activities.

Measurements that take into account the number of times that residents participate in activities or services provide a more adequate conceptualisation of participation than dichotomous measures of whether or not residents ever participate, but these measures sill obscure the complexity of residents' relationships with service providers in an ABI. Attempts have been made to capture nuances in these relationships by describing participation in services and activities in terms of 'engagement'. Popay (2006, p. 2) defines community engagement as "an umbrella term that encompasses a range of different approaches to involving communities of place and/or interest in activities aiming to improve health and/or reduce health inequalities". A number of different models have been developed to reflect different types of activities in which residents might participate, their level of commitment to them and the degree to which they have influence over the activities. Popay's (2006, p. 6) model, for example, relates to the extent of control that community members have over the activities in which they are participating and distinguishes between "the provision and/or exchange of information; consultation; co-production; and community control". In relation to Sure Start services, Garners, Tunstill, Allnock and Akhurst (2006, p. 293) developed a five-

point continuum of access to describe different levels of participation or engagement among service users: “(1) making initial contact; (2) introduction to the service; (3) autonomous take-up of at least one Sure Start service; (4) autonomous take-up of more than one Sure Start service; and (5) autonomous take-up of services other than those provided by Sure Start”. While these approaches might be used to identify *what* takes place when residents participate in activities, they do not help to explain *why* residents participate and the meaning of that participation in the context of their lives. Lawless (2004, p. 387) argues that “engagement is only one step in the process” of working with residents as part of ABI activities and that “once ‘engaged' representatives and leaders from communities can be involved in a wide range of tasks designed to support change on the ground.” His interpretation highlights a gap in understanding in terms of how residents decide to make contact with a service and the processes through which they might develop relationships with service providers through participation. Part of the reason why the models described above are limited is that they explain participation in terms of a linear trajectory from non-engagement to ‘full’ engagement, however that may be defined. Such an approach overlooks the unpredictability of social relations. The experience of ABI participation shows that, in reality, people move in and out of contact with services (Simpson, 2002).

One of the ways in which researchers have sought to make sense of low participation rates among particular populations groups is to identify “barriers” to residents’ engagement (Coe, Gibson, Spencer, & Stuttaford, 2008, p. 447). This approach to understanding participation tends to focus research attention on the actions of providers rather than the lives of residents. For example, Love (2002, p. 325) found that Headstart staff experienced greater difficulty engaging groups who experienced different types of deprivation as staff “often found it necessary to address critical economic and social support needs before parents in this group were able to focus on child development services”. Similarly, the “barriers” to using Sure Start services identified by Coe et al. (2008, p. 450) focussed on steps that Sure Start staff could take to make services more “accessible” and “appealing”, such as the provision of better information. These explanations emerge from an assumption that participation in services will be a positive experience for residents and consequently, explanations about participation are often developed out of the aspirations of service providers, rather than residents. A review by Burton (2004, p. 16) highlights the “taken-for-granted nature of community involvement in much of

the literature" shown by the large number of handbooks and guidance documents that have emerged from research bodies and government.

Despite the emphasis on ways in which providers might improve participation, little attention has been paid to the context in which providers develop their practices for working with residents. Government rhetoric states that the VCS is better equipped to work in collaboration with communities (Department of Health, 2004) but there is as yet little evidence to support these claims and little is known about the ways in which VCS providers work with residents in ABIs. Exploring the views of service providers, Harris and Young (2010) found that the innovative approach that VCS organisations took in developing inter-faith activities within ethnically diverse communities was associated with providing activities that people wanted. Service providers perceived that the relatively small size of their organisations and their relatively informal structures freed them from constraints that statutory providers might experience on what they deliver. Harris and Young (2010) also found that, from the point of view of providers, using local people to deliver community activities gave them "credibility and legitimacy" among residents. More research is needed to explore the influences on VCS providers' methods for working with communities as well as that which explores the experience of developing relations with VCS providers from the point of view of residents.

By focussing on the aspects of participation that might be unappealing to residents, there has also been a tendency to identify surface-level explanations about non-participation and a failure to develop sociological explanations about how participation might relate to residents' lives. Without detailed understanding of the social context in which residents identify 'barriers', there can be little understanding about why such issues might be perceived as barriers to participation by residents. For example, non-participation is often defined in terms of a skills deficit on the part of residents, rather than examining what residents want from services. This is shown in Lawless's explanation for discontinued participation among residents in NDC activities:

> Once people have been engaged, the standard litany of difficulties tends to undermine longer term commitment: burnout, declining interest, intracommunity strife, disquiet at the operation of formal boards, lack of remuneration, formidable time commitments, lack of confidence, lack of perceived skills, and so on." (Lawless, 2004, p. 387).

His account focuses on the skills deficits of residents in terms of what providers perceive is required for participation. The emphasis on provider definitions of engagement ignores the role of resident actions in the development of relations between residents and ABI providers. Whittaker and Cowley (2012) argue that participation in community-level programmes needs to be understood in the context of families' wider lives. Their review of participation in parenting support programmes showed that issues influencing participation among some people might be irrelevant to others. Empirical research suggests that residents' beliefs shape decisions about participation. For example, research by Hothi et al. (2010) showed that many families on deprived estates perceived that services there were targeted at middle-class families and consequently irrelevant to them. Harris and Young (2010) also found that some residents feared being ostracised by their own communities if they participated in inter-faith activities. Examining the ways in which residents conceptualise participation and the ways in which it might be viewed by people in their social network could provide greater insight into the processes that constrain and enable participation.

An emphasis on 'barriers' to participation is also problematic in its depiction of residents as powerless in the process of developing relations with providers. Notwithstanding the policy rhetoric of community-led initiatives, there has been a tendency to assume that providers have more control over the participation agenda in some ABIs (Dinham, 2005). While it is important to recognise that providers might have more control over some of the ways in which activities are delivered, the problems with participation reported in a range of studies show how residents have the power to subvert ABI processes. An unanticipated consequence of ABI community partnerships, for example, was that existing tensions between sections of the community were accentuated by the processes of developing local agendas for activity, making it difficult to develop meaningful plans (Carlisle, 2010; Lawless, 2004). As Dinham (2005, p. 310) argues, this reflects the fact that, in relation to NDC partnerships, the history of relations in an area was not considered and "local people [were] asked to come together as though nothing had ever happened to them before". It also highlights however, that the history of power relations with any community will influence the ways in which residents relate to one another and to providers as part of ABI activities.

Examining power dynamics between residents and providers offers an opportunity to explain how relations between them unfold over time. Bovaird (2007) has

proposed a way of conceptualising ABI activities that emphasises the power dynamics in relations between providers and residents. Building on the work of political theorists in the 1970s (Brandsen & Pestoff, 2006), Boviard's (2007, p. 848) notion of "co-production," enables a "more detailed characterization of the relationships between users and communities and professionalized public services" as it emphasises the roles of both groups in the development of user-provider relationships. As Dinham (2005, p. 309) has argued, there has been a tendency to view "local people primarily as dormant citizens in need of activation [and consequently] their diversity and talents are thereby underestimated and undervalued". Understanding the context in which resident participation develops has important implications for community-led practice but research into ABI engagement needs to support this endeavour. These issues show that engaging with services has not been explored as a sociological process and as a consequence, there is uncertainty about who has benefited from ABIs (Lawless & Dabinett, 2000). Exploring the ways in which relationships develop between residents and service providers in an ABI, with reference to the social context in which these relations develop, has the potential to provide more adequate explanation for the ways in which ABIs have infolded.

3.4 Understanding the consequences of area-based initiatives

Understanding about the changes that might develop in targeted areas following the introduction of ABIs is limited. This is partly due to methodological limitations associated with the evaluation of social interventions and, related to this, limitations in the ways in which ABIs have been conceptualised.

3.4.1 Measuring 'outcomes'

Reflecting the Government's policy commitment to evidence-based policy, all national ABIs developed under Labour leadership were subject to evaluation. Evaluation was also recommended for interventions devised at a local level (Office of the Deputy Prime Minister, 2005). Evaluations were often designed to measure pre-defined 'outcomes', or changes that were anticipated by programme designers and evaluators. In health interventions, outcomes were commonly defined in relation to changes to resident mortality rates, disease prevalence, life expectancy, self-reported health and behaviour change. In NDC areas, for example, there was an expectation that the number of people claiming work-related benefits would be

reduced, that there would be a decline in mortality rates, and an increase in the number of people gaining acceptance into higher education (Lawless, 2004). The emphasis on these changes is understandable, given the rationale for ABIs that were designed to improve health. However, there are a number of problems associated with measuring potential change in these areas.

First, these outcomes were often defined by policy makers, programme leaders and evaluators and did not necessarily reflect the experiences of targeted residents. Research has shown that service users tend to define 'outcomes' in different terms to those used by providers and evaluators. For example, a Joseph Rowntree (2003, p. 3) study into the experiences of social service users found that users perceived that their "experiences [of a service] have an impact on the outcome of the service and are not detached from the outcome". This raises questions about who decides how positive outcomes are conceptualised. Springett (2001) has argued that decisions about what to measure in the evaluation of public health interventions, and the processes through which evaluations are carried out, are influenced by the social environment in which they are developed. The priorities of practitioners and researchers, and the political environment, in which they work, often therefore drive decisions about what to measure. Other research has shown that a number of unintended consequences have arisen from ABIs (O'Dwyer, et al., 2007), which have not been considered in evaluations focused on pre-defined outcomes.

Another reason why evaluations have been unable to document change in pre-defined measures is that they have been relatively short term. The social determinants of health, at which many ABIs were targeted, are known to have a lag effect, and their impacts on health might only become visible after decades of influence. Changes in health-related behaviours, such as smoking and diet, have also been shown to be slow to change (Science and Technology Select Committee, 2011). Health outcomes, as measured by disease prevalence and life expectancy, might therefore take a lifetime to change and evaluations have been criticised (Thomson, 2008a) for being overly ambitious in their attempts to document changes in health outcomes over a few years. Through a systematic review of ABI evaluations in the grey literature, Hardiker, McGrath and McQuarrie (2009) found that interventions designed to change the behaviours of residents in deprived areas were usually evaluated during and immediately after the intervention, with few studies evaluating changes that might have taken place in the months and years

after an intervention. The long-term consequences of ABIs are not therefore well understood.

The relatively short-term nature of evaluations can be better understood with reference to the political climate in which they were developed. Critics argue that political pressure on providers and evaluators shaped the ways in which ABI evaluations were conducted. In relation to one of the Government's flagship ABIs, HAZs, Judge and Bauld (2006) perceive that government desire to demonstrate their success put pressure on evaluators to deliver reports on 'impact' in a shorter-time frame that might have been viable. Imposing expectations about evaluation has also meant that evaluation has sometimes been piecemeal. ABI evaluation processes were often instigated months or years after the delivery of initiatives had started, which meant that they failed to capture baseline data for comparison or missed vital information about the early stages of an initiative (Lawless, 2004).

3.4.2 Searching for 'cause and effect' in social interventions

A political commitment to understanding 'what works' in social interventions has encouraged an emphasis on quasi-experimental designs in the evaluation of ABIs. This also reflects a wider preference for experimental research designs in measuring the impact of health initiatives. Systematic review methods, for example, which prioritise findings from randomised controlled trials, are widely used in the development of evidence-based medicine, which has influenced interest in applying the method to public health interventions (Black, 2001). As Pawson and Tilley (1997) have noted, quasi-experimental designs are appealing in relation to social initiatives as, in theory, they provide the best potential for attributing any changes observed following an intervention to the intervention itself. Using "comparator areas" as a "benchmark" against which to measure changes in targeted areas has been hailed as the "best indicator" of the effects of ABIs (Beatty, et al., 2010, p. 238) and this design played a central role in the evaluation of Sure Start (National Evaluation of Sure Start Team, 2010), HAZs (Benzeval, 2003), and NDCs (Beatty, Foden, Lawless, & Wilson, 2008). However, using quasi-experimental designs to evaluate ABIs raises a number of problems.

Identifying a "control group" against which to compare the effects of social interventions creates particular problems. In their review of community-based intervention programmes Merzel & D'Afflitti (2003) discovered that it was difficult for

evaluators to find a community with characteristics that matched those subject to the intervention. Conditions in different geographical areas differ so widely as to make it impossible to identify areas where residents experience identical social circumstances. As has also been noted, it is impossible to identify comparison sites where no 'intervention' is taking place given that particular policies or service are always being delivered, particularly in deprived areas: many potential comparator areas were often targeted by other ABIs. A particular problem of quasi-experiments in social research, and in health in particular, is that withholding potentially valuable interventions from groups that have similar needs is difficult to justify solely on the basis of advancing knowledge (Bryman, 2008).

The complexity of these interventions also makes them difficult to evaluate. As already discussed, interventions designed to improve the conditions in an area have often involved several different strands of activity. Initiatives have typically comprised a combination of strategies to tackle a range of social issues simultaneously (O'Dwyer, et al., 2007), such as improving local housing while delivering projects to encourage healthy behaviours (Thomson, 2008a). The routes to changed health and socioeconomic circumstances are therefore likely to be diverse (Thomson, 2008a). Petticrew (2011) has argued that it is a desire to understand the combined effects of different strands of action that makes evaluation of these initiatives complex but separation of the different elements of action is artificial. Different aspects of initiatives are often interrelated. The previous chapter showed that the social determinants of health are interrelated and ABIs are delivered on the assumption that several determinants need to be addressed at once. As Weiss (1995) has commented, the interrelatedness of intervention processes has made it difficult for evaluators and practitioners to discern what is taking place and determine how action might lead to change.

Disentangling intervention activity from other local activity also posed particular evaluation problems. Even without the comparator site, it has been difficult for evaluators to distinguish between intervention activity and 'mainstream' activity, making it difficult to connect observed outcomes to particular actions (Barnes, et al., 2003). Exactly what activity and which people contributes to an initiative is not easily defined as boundaries between intervention activity and mainstream public services might not be clear. HAZ partnerships, for example, often merged with existing service provision partnerships and structures and some HAZ activity was delivered through the ordinary day jobs of practitioners (Barnes, et al., 2003). The impact of

competing aims within the setting of ABIs has been well documented, in particular the changing national and local political context (Durham University School of Medicine and Health, 2008; Thomson, 2008). Interventions are rarely, if ever, therefore delivered in a controlled environment. Without a control group, cross-sectional study designs cannot be used to attribute any changes in the population to an intervention as they cannot control for 'confounding' variables within the social context in which initiatives are implemented (Beatty, et al., 2010). Without a clear understanding of the processes operating in the area that influence health outcomes, it has not been possible to specify how interventions have influenced or interrupted these processes. Carr-Hill and Street (2008) have argued that many existing processes within the community could be relevant to the outcomes observed following community engagement initiatives.

The large populations at which interventions are targeted, also makes it difficult to assess the extent to which any observed changes have been experienced across the target population. Careful theorising is also necessary to ensure that aggregated data across communities does not conceal detrimental effects for some groups. The open access of ABIs makes it difficult to assess the cost of the intervention in terms of community resources or unanticipated losses in relation to health gain (Carr-Hill & Street, 2008). It is important therefore, to find methods for assessing whether positive outcomes are experienced community wide.

A further complication in evaluation of ABIs is the inability to specify exactly what has been delivered. A key characteristic of ABIs was the willingness of providers to respond to perceived needs of particular communities. HAZs, for example, were used to develop different plans in different target areas (Thomson, 2008a). Comparing outcomes across programmes delivered as part of the same national initiative has therefore proved problematic. Furthermore, what is delivered might change over time. Reviewing published evaluation data, O'Dwyer (2007) demonstrated that some interventions were not thought by their evaluators to have received adequate resources or time to implement their plans. Without an adequate description of exactly what was done it is not possible to state whether the principles of the programme might be of use in other contexts (Surko, Lawson, Gaffney, & Claiborne, 2006).

ABI evaluations are therefore troubled by the same problems that cloud understanding about the social determinants of health. Research that seeks to identify causal pathways between living in deprived areas and having worse health suggests that there is a complex interaction between many different social processes (Barnes & Cheng, 2006). There have been attempts to identify "mechanisms" within an initiative that can be used to bring about positive changes in order to know which aspects of an initiative are useful (Parry, 2004, p. 497). As Coburn argues, the study of health inequalities has been beset by failure to account for the complexity of the context in which they are produced:

> [There is] a general trend in social analysis to try to isolate the 'independent' effect of one factor among many interrelated factors, rather than analysing the complex conjunctions of many different facets of social life which form social types or wholes. (Coburn, 2011, p. 1).

Stephens (2008) argues that, although an association between conditions might be observable, the pathways between social circumstances and health outcomes are unlikely to be linear. It is impossible, therefore, to identify all the 'unknown' variables that mediate relationship between social processes and health outcomes. Partly for these reasons, the current Director of the Public Health Excellence Centre, Mike Kelly (cited in Milton, Moonan, Robinson, & Whitehead, 2010), has argued that there is a need to work backwards to uncover what takes place in public health interventions rather than predicting what will happen and testing whether predictions are correct. The interconnectedness of social conditions forms the basis of the problems described above.

3.4.3 Theorising change processes

It has been argued that evaluation of ABIs needs to start from the ideas that underpin initiatives in order to better understand how they are expected to make a difference in targeted areas (Bonner, 2003; Sullivan, et al., 2006). Evaluations have been criticised for the absence of clear theory to support investigations into mechanisms of change, without which they will be of little use to exploring whether interventions will work in other contexts (Campbell et al., 2007). There is at present little consensus regarding what practices and theory should underpin an ABI (Dooris, 2004). This is due to the fact that so little is yet known about the processes through which the wider determinants shape health outcomes. Developing understanding about how interventions designed to reduce inequalities might

influence change has the potential to improve understanding about the social determinants of health (Bambra et al., 2009).

A theory-of-change (TOC) model of evaluation originated from the Aspen Institute in America to address problems of complex initiative evaluation (Connell & Kubisch, 1998). The model requires practitioners, supported by researchers, to articulate the connections between initiative activity and expected outcomes in the abstract in an iterative fashion, as an intervention unfolds. Using this model, multiple theories about how an intervention might bring about changes are maintained until they are refuted and dropped (Weiss, 1995). The model is valued as it enables evaluators to incorporate changes made to a programme in their evaluation (Surko, et al., 2006). Potentially, this model of evaluation provides an opportunity to specify links between different stages of an intervention and observed changes, identifying unknown factors that might influence change (Judge & Bauld, 2001). In practice, however, this method is beset by many of the same problems described above as will now be explored.

Given the limited understanding about the social determinants of health, practitioners have found it difficult to specify the processes through which changes might take place. Examining Sure Start programme TOC models, Melhuish et al. (2007) looked at associations between specified outcomes (for example, parenting skills) and the extent to which principles were achieved (for example, the extent to which there was low staff turnover). They found that, collectively, programmes that scored higher in terms of quality of adherence to the principles scored higher on outcomes. This suggests that some of the principles were associated with better outcomes but does not show whether or how the principles shaped the outcomes because steps in the process, from the principles to the outcomes, are missing. Furthermore, theories developed throughout the process of the evaluation are supposedly refined as 'evidence' from on-going evaluation emerges. This leaves evaluators with the same problems described above in that any changes observed, cannot necessarily be attributed to the programme, making it difficult to assess whether the theory holds weight. In this respect, the 'black box' of the intervention remains unopened as the focus remains on inputs, outputs and outcomes without reference to the processes through which one links to the other (Burton, Goodlad, & Croft, 2006).

As a result, theories in this vein are often based on a psychological model of behaviour change and are therefore focussed at the individual level rather than the specific context in which initiatives operate (Merzel & D'Afflitti, 2003). This is inadequate because, as has already been argued here, intervention processes will interweave with specific community factors to shape what happens (Merzel & D'Afflitti, 2003). Barnes et al (2003) found that the theories developed to explain what took place in HAZs could not be applied to all elements of the programme. The theories therefore did not take account of a multiplicity of factors that might affect the programme and developing a theory for a whole programme was impossible. Given the difficulties predicting pathways, in practice, TOC models are often not articulated until after the initiative has finished (Harting & van Assema, 2010). Furthermore, developing a theory requires consensus from practitioners who are constrained by the political climate in which they work (Weiss, 1995). Competing motivations among providers can make it difficult for consensus to be reached (Barnes, et al., 2003).

The difficulty of delivering ABI activities according to initiative plans also mean that it is difficult to specify whether a programme has adhered to the theory. Where the intervention is adapted to meet the needs of people it becomes hard to specify the mechanisms through which change might develop and adherence to any TOC is lost. Theories that allow for change are therefore required. Judge and Bauld (2001) sought to overcome some of these problems by combining a TOC model with realistic evaluation methods. A critical realist perspective to evaluation is more focussed on the social context in which initiatives are implemented (Pawson & Tilley, 1997). There are similarities between the two approaches in that both are focussed on attempts to use “stakeholders’ knowledge” to surface a theory of best fit to explain causal chains of events (Pawson & Tilley, 1997, p. 153). Realist methods allow for complexity in that factors in the environment that constrain or enable the ‘mechanisms’ of the initiative are accommodated within the theory. However, the approach does not provide an adequate account of the ways in which initiative activity might be changed by activity in the social context. This model assumes a linear and somewhat static pathway between events and suggests that certain events can be identified as ‘mechanistic’ while others are labelled ‘context’. This separation overlooks the ways in which people can change what happens in an initiative. To reify some processes as mechanistic, denies the way in which people shape what happens.

Barnes et al. (2003) have drawn on complexity theory as a way of connecting processes and outcomes. This approach helps to overcome some of the problems inherent in a realistic evaluation as it does not assume linear path between cause and effect. Instead, emphasis is placed on the ways in which social systems at a local level can influence global systems and vice versa (Byrne, 2001). This is helpful as it suggests that context and mechanisms are not clearly discernable from each other but rather, that each influences the other. While this theory enables a more accurate representation of what takes place in an initiative, it offers more description than explanation. This is partly because of the dependence on "systems" as a unit of analysis (Byrne, 2001 para. 4) which shifts the emphasis away from individual actions. Using these ideas, Barnes et al. (2003, p. 279) attribute unanticipated consequences that emerged in HAZs to "serendipity", which tells us little about the ways in which such consequences developed.

Social capital is a concept that has been drawn on to explain how residents benefit from participation in an ABI. In public health research interest in social capital has focussed on the benefits to health that might be accrued through social support, social cohesion and the potential for improved access to material goods through connections with particular groups (Szreter & Woolcock, 2004). However, the ways in which these aspects of social networks might influence health is not well understood and there is criticism that the concept of social capital is under-theorised in relation to health. An increasing number of authors have criticised the way in which social capital has come to be understood as an explanatory mechanism in itself, rather than a way of conceptualising human access to resources (Moore, et al., 2006; Szreter & Woolcock, 2004). Reliance on this concept in isolation from other related ideas limits understanding about the ways in social capital might be produced and used. Even though networks might be utilised for benefit, the concept of social capital shifts focus from social networks to what is produced from them. The concept does not, therefore, help to explain how social networks are constructed (Magnani & Struffi, 2009). In relation to ABIs, there is a lack of understanding about how social capital might be generated among residents through contact with services and how it is then utilised by residents to their advantage. As the main focus of this study is the way in which relations develop, there is potential to use this concept to examine whether ABIs might be used to influence social change.

Moore et al. (2006), argue that the considerable influence of Putnam's communitarian definition of social capital in the field of public health has obscured the role of social networks in the development of health and wellbeing. Putnam's (2000) ideas focussed on the benefits of membership in formal organisations and extolled the benefits of such membership for community cohesion. Using Bourdieu's (1986) definition of social capital, Portes (1998) emphasises the fundamental role that social relationships play in permitting access to the resources possessed by associates in a network and in determining the amount and quality of the resources that they possess. To understand how social capital might be developed therefore, there is a need to explore how it is produced and accessed within networks, particularly those in areas of deprivation. There is some indication that social networks are developed among residents through ABIs and that this leads to benefits for residents. Harris and Young (2010, p. 42), for example, found that providers facilitated social contact between groups of people who would not normally spend time together and that spending time with others on a task led to trust and greater "cohesion between residents". This provides important insight into the ways in which providers work with residents but does not explain the processes through which networks are constructed and how trust develops within them. 'Cohesion' is defined by Harris and Young (Harris & Young, 2010, p. 42) as "interaction and mutual accommodation" which provides little understanding about the ways in which residents benefit from contact with each other and with providers.

Little is also known about the ways in which contact with service providers might lead to changes for residents in areas targeted by ABIs. Stanton-Salazar (2010, p. 1075) uses the idea of social capital to explain how "institutional agents", such as teachers and youth leaders) act to "transmit" resources to young people. Cameron et al. (2009, p. 393) also found that service providers in a housing service acted as a "crucial link" between users and a range of other services that they might benefit from as they helped them to "navigate the bureaucracy" of using services to find and moving into a new home. Coalter (2007) argues that social capital remains an under-theorised concept, particularly in relation to the pathways from participation in services to particular outcomes. Woolcock (1998) argues that part of the difficulty in applying the concept to understand social phenomena is the failure to disentangle 'causes' and consequences in the use of the term social capital, for example trust has been interpreted as a source as well as a product of social capital. Developing more adequate explanations about the ways in which relationships develop over

time and the benefits that residents accrue from these relations has the potential to improve understanding about social capital.

3.5 Conclusions

The aim of this chapter was to critically evaluate knowledge on how ABIs develop. Overall the emphasis of research on ABIs reflects the emphasis of the Government on evaluation, particularly in relation to outcomes. Where implementation has been explored it has tended to be in static rather than dynamic and developmental terms. ABIs have also tended to be under-theorised. The review showed that social processes that form ABIs, such as partnership development and resident participation in services and activities, are not well understood. This is partly because there has been a tendency to separate the context in which ABIs are delivered from the people who deliver and participate in the activities. There is also limited understanding about the processes through which ABIs might be used to influence change in targeted areas. The lack of evidence can be explained in part by the tendency to search for causal mechanisms and a failure to appreciate ABIs as a series of relational processes. The following chapter examines the ways in social theory might be used to inform research into how area-based initiatives develop.

Chapter 4

Towards a sociological understanding of area-based initiatives

4.1 Introduction

This chapter sets out the theoretical framework that informed the research. The research was concerned with both the use of extant theory and the development of new theory to explain the processes that emerge out of ABIs, seeking to blend a grounded theory approach with sensitising concepts from figurational sociology. The review in the previous chapter indicated that ABIs remain under-theorised; this chapter describes how a sociological perspective might be used to inform the development of a substantive theory of the ways in which ABIs, such as TW, unfold over time. The chapter draws predominantly on ideas from figurational sociology but is informed by wider sociological ideas. The central premise of figurational sociology is that social phenomena can be best explored through examination of the interdependencies between people (van Krieken, 1998). These interdependencies are conceptualised as forming figurations, or networks, of interdependent people (Elias, 1994). A number of related concepts relevant to this thesis are also examined here, including power balances, process-reduction and habitus. These concepts are dealt with separately for the purposes of explanation, but they are, nevertheless, integrated concepts. The particular ways in which the concepts relate is discussed throughout the following discussion about their potential utility in developing a substantive theory about ABI development.

4.2 Understanding social connections

The central concepts that make up Elias's framework emerged out of a large-scale study, the first phase of which was completed in 1933, of the long-term processes through which modern societies were formed (Elias, 1994). Ideas from figurational sociology have been successfully applied to examine organisational change within the NHS, shedding light on the way in which unintended consequences emerge from the interweaving actions of a range of professionals working in the NHS (Dopson & Waddington, 1996; Mowles, 2011). The ideas have not, however, so far been applied to the field of public health in general or ABIs in particular. The

application of these ideas to the examination of a policy initiative like TW presents an opportunity to examine the unintended consequences that have emerged from ABIs in a new light.

Figurational sociologists conceive of social action as relational. A figuration is defined as a structure of "reciprocally oriented and dependent people" (Elias, 1994, p. 214). People are connected to one another via different types of interdependencies including those based on economic resources, emotion, information or status. Figurations thus reflect the inescapable interdependency of the human condition. As Goudsblom (1977, p. 7) observes, all humans are dependent on others because from birth, "all of [a] child's learning, its learning to speak, to think, to act, takes place in a setting of social interdependencies." As figurations are not reducible to people, neither the individual nor the figuration can exist independently (Elias & Scotson, 1965). The dualism between individual and society, or individual agency and social structure, is an issue that has "dog[ged] social analysis" (Bottero, 2009, p. 400). Figurational ideas provide a means of subverting this dualism by focussing on connections between people which are seen to form dynamic social structures (Elias, 1991). By considering the interdependency of people living within a geographical community, this focuses social analysis on a collective of people rather than on the structures that they are seen to produce. This approach avoids reification of social structures reminding analysts that people form the basis of any system. As Dopson (2005, p. 1128) has expressed succinctly, the impact of structures, such as organisations or cultures, can be thought of as "nothing other than constraints exerted by people over one another and themselves". The idea of figurations also recognises that interdependencies impose constraints on behaviour (van Krieken, 1998). In this respect, people can only be understood through their relationships to other people. To understand either the collective social group or the individual, the starting point for analysis becomes the relationship between the two (Elias, 1991). Communities targeted by ABIs might therefore most usefully be conceptualised as figurations of interdependent people and individual action understood with reference to the interdependencies between people.

Conceptualising communities targeted by ABIs in this way encourages appreciation of the fact that people living in targeted areas are embedded in social networks that extend beyond the geographical area of the initiative. People are caught up in numerous webs of interdependency of many kinds at any one time (Elias, 1978).

Thus, residents targeted by an ABI might simultaneously be caught up in networks that reflect, at the very least, kinship ties, professional connections, or place of residence. Significantly however, in modern life networks of interdependence extend beyond personal connections and include interdependencies that reflect the increasingly specialised division of labour (Elias, 1994). Interdependencies can therefore extend across vast geographical areas and to large numbers of people and residents targeted by an ABI might be considered to be interdependent with service providers, political leaders, communities of identity based within and beyond the initiative area. As shown in the previous chapter, differences among people targeted by ABIs have been shown to make the delivery of ABI activities more difficult (Carlisle, 2010). A figurational perspective provides a way of conceptualising people as simultaneously forming a number of different networks of interdependence which might have resonance for their experiences at different times and in different contexts. Exploring the ways in which people are shaped by their connections with people beyond the local area, residents in neighbouring areas for example, has the potential to explain different responses to ABIs among people.

Figurational sociology also encourages emphasis on the ways in the actions of people at the local level might be influenced by figurations that encompass larger numbers of people. Service providers commissioned to deliver an ABI will be constrained by their interdependence with, among many others, national policy makers, staff in global corporations and staff in non-governmental organisations. The ways in which wider figurations, encompassing large numbers of people, influence local actions and vice versa has the potential to explain the ways in which relations unfold in an ABI. This conceptualisation helps to challenge the macro-micro divide that has limited analyses of ABIs so far, emphasising instead, the ways in which processes at a 'national level,' such as the development of new economic policies, are dependent upon and impact on events at a 'local level'.

4.2.2 Dynamic social relations across time

Conceptualisation of human relations as interdependent also permits a view of an area-based community as dynamic. Elias perceived that the constant interweaving of human actions can be thought of as figurations of interdependent people, which exist in a state of flux (Elias, 1991). As Bauman (1979, p. 119) has summarised, the "fluidity of any current pattern of interdependencies" enables figurations to be simultaneously "stable" and "dynamic." This challenges conceptions of social 'order'

as a normative condition of human experience. This conceptualisation of communities proposes that people can be part of numerous communities simultaneously but also that their connection to any community is temporal and dependent upon the behaviour of others. If interdependencies between people are considered as dynamic, it must follow that the meaning of place will change over time. Dynamic social interdependencies shape the context in which people live so changes in the social context of an ABI might more helpfully be understood to reflect changes to the ways in which people relate to one another. This raises questions about the ways in which initiative providers can respond to such changing needs.

Of particular relevance to the study of planned social action, such as the implementation of TW in Ellesmere Port, is the theory that interdependencies both reflect and stimulate complex interweaving actions among people. The interdependency of human actions and intentions results in consequences that no one group or individual intended (Elias, 1978). As service providers within an ABI are interdependent with other providers and service users within their local area, and with funders and policy makers at a national level, their capacity for co-ordinated action will be constrained by the actions of a large number of people. Elias perceived that the effects of interweaving human action could be perceived as forming a social dimension which no one group or individual could directly control; he described the “web of interdependent functions by which people are tied” as having “a weight and laws of its own” (Elias, 1991, p. 15). As with a conversation, the path of which cannot be pre-determined as one side of the conversation is always dependent on the other, all human action is shaped according to the actions of others with whom we are dependent (Elias, 1991). Increasingly complex interdependencies between greater numbers of people in modern industrialised societies like the UK have made it more difficult for people to identify the constraints on their behaviour (Elias, 1994). The lengthening chains of interdependencies between different sections of societies are increasingly difficult to comprehend. The task of sociology is to better understand these webs of interdependency (Dopson, 2001). A focus on the interweaving actions of people and the connections between them could provide greater insight into the processes through which co-ordinated working and resident participation develop in ABIs. An important aspect of social relations for understanding unintended consequences is power, to which attention will now be turned.

4.3 Understanding power in area-based communities

Power in figurations determines the outcome of interweaving actions. The balance of power in a figuration is an aspect of the interdependencies. Where there are heavy imbalances of power, for example in relation to the professional status of providers within a multi-sector group, some parties might be able to exert more control over events than others. Elias made use of a game analogy to illustrate the ways in which the network of social relations determines the outcomes of human action. Comparing life to a competitive game, Elias (1978, p. 82) argued that, as all "players" are interdependent, their "moves" are limited by those of others. There will therefore always be unexpected outcomes in a game as players actions are mediated by the actions of others. In any 'game', some 'players' have more power which gives them greater influence over the outcome of a game, but as even the most powerful players are constrained by the decisions and actions that other players take, ultimately no one player can control the outcome of any game. In this respect, even the most powerful people are constrained by the "law of [the] mighty human network …. [people have] only a greater or lesser scope for decision" (Elias, 1991, p. 51). As more players join in, any game gets more complex and the development and direction of the game becomes more opaque (Dopson, 2001). So, in more complex societies, where the chains of interdependency between people are longer, any one group or individual will have less control over social plans as their action which will depend on the actions of many other people.

ABIs in modern, industrialised societies necessarily reflect complex processes involving large numbers of people. Examining the ways in which different groups in an area targeted by an ABI are interdependent provides an opportunity to explore the ways in which competing local aims are played out. This is potentially useful in the face of what Hunter (2007, p. 22) describes as an "implementation gap in respect of public health" policy. In understanding why plans are not implemented as expected, figurational sociology offers a framework for explaining the processes through which action develops. As Bauman (1979) has summarised, a perspective informed by figurational sociology is helpful for understanding planned change because it allows that some actions will be less likely but maintains that no future events are predictable. Applying this model of planned social action to the study of organisational change in the NHS, Dopson and Waddington (1996) noted that change management is influenced by the interweaving intentions and actions of a large number of people and that predicting how changes will unfold is impossible. They argue that monitoring and evaluation provides a means of achieving better

understanding about planned social actions, which provides an opportunity for planners to exert more control over outcomes. ABI evaluations therefore require more theoretically-informed knowledge about the processes through which plans develop.

Elias (1978, p. 116) conceptualised power as “an attribute of relationships”, which does not exist without reference to other people. In this respect, power can be understood to be polymorphous in that in any set of relations there might be different dimensions of power that benefit anyone person at any one time (Elias, 1978). Power reflects the “social opportunity to influence the self-regulation and the fate of other people” (Elias, 1991, p. 52). One’s place in a figuration determines opportunities for influence. Where a specific group of people, such as service providers, has influence over other groups’ and people’ access to resources, such as training opportunities, they might be said to have more power over training outcomes for some people. As these providers might be dependent on residents’ participation in courses (in order to meet recruitment targets for example) their monopoly on power cannot be complete. Consequently, it is more helpful to consider power *balances* between groups and people in order to understand their behaviour.

As figurations are dynamic, so are opportunities for influence. The balance of power between groups and people might therefore change according to different social contexts (Dopson, 2001). This suggests that power relations also need to be examined developmentally. Changes in the balance of power between groups and people can be accounted for through consideration of changes in the way people are bonded together. This is helpful in relation to understanding social inequalities as balances of power reflect on-going struggles between people for influence over one another. Inequalities should therefore be understood through attention to the ways in which people exert power over others. Building on the ideas of Campbell and Murray (2004, p. 189), communities can be understood as “microcosms” of the “social relations of the wider societies in which they are located”. Experiences of people within a geographic area reflect their relationships with a wider network of people which makes area-based communities a good site for exploring the social determinants of health.

This provides a helpful framework for understanding how increased control and influence among particular groups might be mobilised power through an ABI.

Understanding power as influence and control focuses attention on the ways in which residents relate to others. Of relevance to understanding how residents might develop greater control and influence over their lives is the structure and dynamics of their social networks. Bourdieu (1986) conceptualises power in terms of capital that might be exchanged for individual benefit. As the previous chapter showed, attention has so far focussed on the ways in which residents might develop social capital. Bourdieu (1986) described the way in which power is legitimated and rendered valuable within specific fields (or structures of social relations) through struggles between people and groups. To consider this in figurational terms, the balance of power within different figurations determines how particular resources are valued. Figurational sociology therefore offers an opportunity for exploring the ways in which these power struggles operate. Research that examines people's interdependence and the ways in which power operates within these interdependencies can potentially illuminate the ways in which power is developed and used at different points in time, showing how interdependencies might constrain and enable production and use of capital within communities.

The concept "established and outsiders" provides a way of thinking about the lines along which power might be demarcated in small communities (Elias & Scotson, 1965, p. xv). Applying the theoretical framework that he developed to the examination of resident relations within a small community, Elias (with Scotson) (1965) argued that power balances within a figuration could be influenced by one's status as either 'established' or 'outsider'. Elias (1997) later proposed that this concept could be applied to explore processes of group formation and social conflict on a larger scale between a range of groups, including ethnic or social class groups. It has since been used to explain negative stereotyping of 'drug-users' in sport (Dunning & Waddington, 2003), demonstrating its utility across figurations of varying size. The introduction of a new set of projects into a small town as part of an ABI has much in common with the social changes examined in Elias and Scotson's (1965) study, in that planned social action influences changes to the ways in which groups of people were interdependent. Observing caution that the 'established-outsider' concept might dichotomise the experiences of different groups (see Bloyce & Murphy, 2007), it might usefully be applied to examine power relations between providers whose relation to one another is shifted in light of the introduction of an ABI.

4.4 Understanding area-based initiatives as a developmental process

A particular strength of applying figurational ideas to the study of ABIs is the focus such ideas place on social processes in understanding social phenomena. Elias (1978) argued that contemporary phenomena could only be understood with reference to earlier stages of human action criticising the tendency in sociological study to describe people and their relations to other people in static terms in what he described as process-reduction. Figurational sociology encourages analysis that incorporates the historical context of social relations within an area. Elias (1991) argued that because social phenomena emerge from the interweaving of individual actions, it is impossible to locate their origins to any precise point or moment in time. Interweaving actions result in dynamic interdependencies and shifting balances of power between people over time. Understanding the historical basis of contemporary power relations between providers and between providers and residents in targeted areas has the potential to explain the ways in which relations between these groups unfold when an ABI is introduced. Examining social processes prospectively, and thus developmentally, therefore has the potential to better explain unplanned events.

Elias also perceived that an individual's place in a network of relations with others strongly influences disposition, tastes and ambitions (Elias, 1991). He used the term habitus to explain how a process of socialisation shaped people' expectations and actions. Habitus can be described as a second nature reflecting dispositions tastes and ambitions. It describes "taken-for-granted ways of perceiving, thinking and knowing" about the world (Paulle, van Heerikhuizen, & Emirbayer, 2012, p. 71). Habitus is developed through interactions with other people, that is, through processes of socialisation that are more influential during childhood, when people are more influenced by others around them. A particular criticism of habitus is that it is deterministic and pays too little attention to rational calculation in decision making (see for example Bottero, 2010). Elias (1994), however, described the process of habitus formation as never ending, capturing the way in which habitus could be re-shaped through changing interdependencies. The concept captures the way in which ideas about the world become imbued in the psyche over a period of time. Habitus is used to depict the site at which mental 'structures', what Elias (1994, p. 184) referred to as "personality structures" interact with social structures (Reed-Danahay, 2005). Lizardo explains the ways in which Bourdieu conceived of this interaction in habitus formation, which reflects Elias's definition to some degree:

> The intersection of field and internalized dispositions in habitus is in fact the meeting point of two ontologically distinct but mutually constitutive structural orders (objective and internalized) and not the point at which "agency" meets structure. Bourdieu was emphatic on this point. For him, ". . . the most obscure principle of action . . . lies neither in structures nor in consciousness, but rather in the relation of immediate proximity between objective structures and embodied structures-in habitus" (Bourdieu, 1996b, p. 38, emphasis added). (Lizardo, 2004, p. 381)

Elias's use of habitus however, focused more attention on the way in which people' perceived place in a network of others contributes to the process of habitus formation. He described the way in which people' sense of self was defined in relation to others, claiming that "the manner in which an individual sees … himself … depends on the structure of the … associations within which he learns to say 'we'" (Elias, 1991, p. 38). People are born into a network of relations that has a historical context, such as a family's history, the history of the local area, and consequently, the history of these relations informs the process of socialisation. As Paulle (2012, p. 7) explains, "specific social configurations, conceptualized both on micro and on macro levels, serve as the sources of second natures and as the dynamic contexts in which habitus (plural) function". The idea of a collective habitus can therefore be used to explain the particular norms of groups. Elias (1991) described how different figurations of people can embody a particular habitus. Reay (2004) argues that habitus at the level of a group is a less complex construct than that which exists at the individual level and contains the imprints of many differentiated groups. Elias described group habitus as the "soil" from which an individual habitus grows, stating that, in complex societies, an individual "bears in himself or herself" the layers of many groups (Elias, 1991, p. 183). Individual and group habitus can help to explain similarities and differences in response to social situations. A group habitus might be used to explain similar expectations about working with residents among providers from the same sector for example, but the biographies of individual providers will also shape different responses to events and activities.

Hitherto, insufficient attention has been given to the historical social context within which ABIs are implemented, but the evidence indicates that this is of considerable importance if greater understanding about 'partnership' and resident 'engagement' is to be generated. Dopson's (2005) use of an Eliasian approach to understanding the processes through which medical innovations penetrate clinical practice is helpful for demonstrating that innovations themselves are embedded within complex

social networks. Her study highlights the way in which contemporary practices are infused with the ideas and practices of previous generations. By demonstrating the multiple influences on the treatment decision of medical practitioners in her study, Dopson shows how 'innovations,' which themselves have been developed out of previous human knowledge and experiences, fit into a web of existing networks. This is helpful in terms of thinking about the way in which a public health intervention might mediate networks of service providers and residents, conditioned to behave in particular ways. Local people and providers will respond to the ideas put forward by the initiative according to their own experiences and knowledge, which relates to figurations, past and present, of which they are a part. Despite its instability, the habitus of particular figurations is not amenable to change by any individual as it is controlled by the collective action and memory of the group, but ABIs offer an opportunity to explore the processes through which group habitus is challenged and reformed through interaction between providers and residents.

4.5 Conclusions

This chapter has described a sociological perspective that might provide a route to developing more adequate understanding about the ways in which relations develop over time when an ABI is introduced into an area. Figurational sociology provides a framework in which the examination of relations can be conducted with particular emphasis on relations as dynamic interdependencies influenced by balances of power which develop out of historical processes. The following chapter sets out the ways in which these ideas informed the study design and research processes.

Chapter 5

The research process

5.1 Introduction

The purpose of this chapter is to describe the processes through which the research was carried out and explain the choices made in relation to methodology. Critical reflection on the research process is used to assess how decisions shaped the emergent findings. The chapter starts with a discussion of the ethical issues raised by the research and the ways in which they were managed throughout the research process. Following this the epistemological assumptions underpinning the research are discussed, with particular reference to the role of theory in the study and issues of research involvement and detachment. The research design and methods used for the study are then described and the consequences that emerged from these choices are examined.

5.2 Ethical considerations

Ethical approval for the study was obtained from the NHS Liverpool Paediatric Research Ethics Committee in May 2009 (see Appendix 1) and the local PCT Research and Development Office approved the project during the same month. As "ethical issues can and invariable do arise at all stages of the research process" (Bryman, 2008, p. 117) the research protocol approved by the Ethics Committee was used as a framework for carrying out the research according to ethical practice. In its role as regulator for all research involving NHS patients and staff, the National Research Ethics Service undertakes to "protect the rights, safety, dignity and well-being of research participants; and to facilitate and promote ethical research that is of potential benefit to participants, science and society" (National Research Ethics Service, 2009 para. 1). This process highlights the fact that researchers must balance commitment to generating knowledge with respect for the rights of others (British Sociological Association, 2002). This balance was managed throughout the study with consideration to five key ethical principles.

The first of these principles is that all persons have unconditional worth. This principle, originating from the work of Immanuel Kant (as cited in Beauchamp & Childress, 2009) is sometimes referred to as the "golden rule" of ethics (Brook,

1987, p. 363) as classification of persons as rational and moral beings is a prerequisite for a belief that action should be shaped by ethical principles. The second principle assumes that persons should be afforded liberty and agency to act according to their own needs and desires (Beauchamp & Childress, 2009). Adherence to this principle requires that persons are given a right to hold views, to make choices and to take action according to their own beliefs. In the context of social research, this principle demands that research participation must be voluntary and that it should not require people to perform actions at odds with their own beliefs (Oliver, 2003). A sociological perspective on human behaviour challenges the notion that people can act with complete autonomy, without reference to the actions of others. If human action is viewed as interdependent, it follows that people cannot fully enact decisions with complete liberty from the influence of others (Elias, 1978). Beauchamp and Childress (2009, p. 102) argue that "mythical ideals" about "full autonomy" are not helpful in the application of ethical principles and that the degree to which "substantial autonomy" might be performed is best judged in a particular context. For example, as this research was supported and paid for by the co-ordinators of TW, there was a risk that service providers commissioned by the co-ordinators would feel pressure to participate. This was managed to some extent by ensuring that participation and non-participation by these providers was confidential. Despite this, it was not possible, or even desirable, to control the way in which TW commissioners discussed the research with providers and it is possible that some providers experienced a sense of obligation to participate.

The third principle, non-maleficence, states that researchers should do no harm to others (Beauchamp & Childress, 2009). Harm is a concept open to interpretation and might be considered to include emotional as well as physical harm. Given the potential vulnerability of some of the residents targeted by the initiative examined in this study, including those people with long-term mental health problems, there was a particular need to ensure that their recruitment and participation in the research did not cause any distress. This was managed to some degree by treating consent to participate as an on-going process (Richards & Schwartz, 2002), creating several opportunities for TW users to withdraw from the research. The fourth principle of beneficence denotes an obligation to actively promote or advance the welfare of others. The moral responsibility that might be imposed by such a principle can only reasonably be judged according to the specifics of the context in which it might be applied. In relation to this research, the interests of participants were promoted whenever possible. For example, the initiative co-ordinators participating in the

research perceived that the study presented an opportunity for critical reflection on their practice. At their request, emerging findings were presented to a variety of local audiences in provider and co-ordinator settings. In this respect, there was an attempt to ensure that the needs of participants were supported by the research.

Finally, the principle of justice relates to fairness and the equal treatment of all people (Beauchamp & Childress, 2009). When applying the principle of justice to research practices, researchers are made aware of their obligation to treat people in accordance with the laws of the country in which they are working. Adherence to a moral code of justice however, requires a large degree of interpretation. For example, there is dispute amongst social researchers as to whether participants should be paid for their contribution to research in order to establish equality between participants and paid researchers (Grady, 2001). In this research, a decision was made to reimburse participants for any travel expense but participants were not paid for their time. In the case of service co-ordinators and providers, there was an appreciation that the providers were participating in work time as part of their paid role. In relation to resident participants the case was less clear. It was anticipated that payment might undermine the voluntary nature of participation among residents, making it difficult for people to withdraw their consent part-way through the process. Attempts were made to give residents more control over the research process in other ways, for example, ensuring that participants had control over the location and timing of interviews. Although researchers typically have more control over many aspects of the research process than participants, in terms of the agenda and format (Kitchin, 2002), the way in which power is negotiated between researchers and participants needs to be acknowledged, challenging the notion that power can be bestowed to participants (Bowes, 1996). The balance of power between the researcher and different participants varied in different circumstances that arose throughout the study, as described in the sections below. The principle of equality informed an emphasis on frank and open communication with research participants as part of the process.

There were instances in which it was not possible to maintain compliance with all of these principles simultaneously because each principle prioritises a distinct element of social interaction. For example, information was sometimes obtained through the research process that might have been useful to TW co-ordinators in the development of activities, but this information was withheld in order to protect the anonymity of research participants. Rather than providing a set of rules to follow, the

principles described above provided a framework in which to make decisions relating to the research. Discussion within the supervision team and advice from both the Ethics Committee and the local Research and Development Office informed decision making as well as guidance set out in the University of Chester's Research Governance handbook. The ways in which the principles described above informed research practice and the decisions made in the field will be demonstrated more fully in the account of the research processes described in this chapter.

5.3 Exploring social processes: epistemological and ontological considerations

An initial review of the academic literature relating to ABIs suggested that in order to better understand these initiatives, more attention was needed on relations between people. The overarching aim developed for this study was to examine the social processes through which ABIs develop over time. The specific objective was to examine how relations between people living and working in one area targeted by TW developed over time. It was anticipated that this would lead to a better understanding of the consequences that emerge when an ABI is introduced into an area. The research was therefore aligned with an interpretivist epistemology in order to understand the meaning that people apply to their experiences (Blumer, 1969). Interpretivist ideas are based on a belief that knowledge about the social world might be generated through the application of methods that differ from those used in the natural sciences (Bryman, 2008). Knowledge is understood to be built through the interpretive work that people conduct to make sense of their lives (Bryman, 2008). Interpretive approaches to understanding social phenomena largely originated from the work of Weber (1947), who argued that the role of social science was to develop *verstehen,* an empathic understanding of the social experiences of others which facilitated explanation of the social world (Bryman, 2008). As quasi-experimental designs have so far proved inadequate to explain what takes place in an ABI, there is a particular need to focus on the ways in which people living and working in targeted areas make sense of what happens when an ABI is introduced there.

The literature review also highlighted a need to focus on the ways in which relations between people in an area targeted by an ABI change over time. The research therefore had a commitment to explore relations developmentally and was most closely aligned with a constructivist ontological perspective. Research based on a

constructivist view of the world seeks to reflect a 'reality' that fits as closely as possible to that of participants' experiences (Oakley, 1999). Such an approach can be contrasted to one which seeks to objectively identify an existing social reality (Pawson & Tilley, 1997). A constructivist perspective affords an opportunity to examine the ways in which residents' and providers' perspectives on local services might both differ and change over time as an ABI unfolds in their area. These ideas are in keeping with a sociological perspective that emphasises the fluidity of social relations and depicts social phenomena as the temporary consequences that emerge from interweaving actions of people (Elias, 1991). The account generated through this study was understood to represent an imperfect reflection of the experience of TW in that, although valid, it could not capture developments beyond the life-span of the research.

A constructivist ontological position allows multiple interpretations of the social world to exist. Research suggests that ABIs are experienced differently by different groups of people, which has made it difficult to assess the consequences that follow from their introduction to an area. An emphasis on the ways in which people construct meaning in relation to their experiences helps to provide a better understanding of their actions in relation to a specific context. Expressed another way, understanding how people construe ABI activity and their participation was expected to provide a more valid explanation for their behaviour than has hitherto been achieved.

5.3.1 Capturing complexity: research paradigms

This research was predominantly informed by a qualitative paradigm but also drew on quantitative research to develop a more comprehensive account of TW. The distinction between qualitative and quantitative paradigms is sometimes considered to be exaggerated (Pope & Mays, 1995) and mixed methods research is becoming increasingly popular in the social sciences (Bryman, 2006). In terms of their epistemological underpinnings, it might be most appropriate to view these paradigms operating somewhere along a continuum between positivist and interpretivist paradigms (Bryman, 2008). Mason (2006) has argued that as social experiences are multi-dimensional, in that they are (for example) emotional, temporal, sensory and spatial, they must be explored from multiple dimensions in order to explain them. Mason (2006, p. 12) suggests that researchers need to be open minded as to the ways in which they approach "the multi-dimensionality of

lived experience" and should not be limited by the constraints of particular research paradigms.

In this study, qualitative methods provided an opportunity to examine people' accounts of living or working in an area targeted by an ABI. Understanding how residents and service providers make sense of their experiences of TW had the potential to reveal the assumptions and interpretations on which their actions were based. Qualitative researchers usually seek to uncover the social world from the point of view of participants and as such, qualitative research is usually more focussed on human experiences and how people make sense of their social world (Gibbs, 2007). The benefits of drawing on qualitative accounts have been summarised in the following way:

> People's talk is a source not only of recapitulation or description, but also of understanding and evaluation. People not only have experiences, they can assess the value of those experiences in relation to their lives. (Popay et al., 2003b, pp. 55-56).

Quantitative data were used in the study to examine experiences of TW from a different perspective and to test out some of the explanations emerging from qualitative accounts. These data helped to show the complexity of relations between people involved in an ABI. Increasing the number of perspectives from which an experience is viewed is more likely to shed light on explanatory processes. In particular, it is possible to see how combining a variety of research methods challenges the theoretical divide between what Mason (2006) describes as macro (or public) experiences and micro (or individualised) experiences. To frame this view in Eliasian (1994) terms, it can be said that events at a global, regional, local and individual level operate in interdependency, their combined effect impacting on lived experiences. In relation to TW, mapping the geographical distance between projects and their users, for example, draws on 'macro' notions of space and place to explain how the initiative operates, while methods that seek to explore personal views on the initiative provide insight from an individual or 'micro' level. These sets of data were combined in an effort to provide a more adequate account of what took place in the initiative, making valid explanation more viable. As Elias (1991, p. 48) has argued combining qualitative and quantitative data, " – far from contradicting each other – yield, if properly linked, a more revealing, more adequate picture".

Triangulating the findings generated by different research methods also enables the researcher to cross−check the accuracy of interpretations (Bryman, 2008). By comparing findings from multiple data sources the researcher can identify 'patterns of convergence' or divergence in order to develop a more "comprehensive" view of a phenomenon (Mays & Pope, 2000, p. 51). Mason (2006) argues that efforts to consolidate findings generated by different methods can obscure the particular strengths of different methods. She suggests that researchers should be open to the possibility that their findings do not generate a neatly consistent explanation and that multi-dimensional explanations might more adequately express the complexity of multi-dimensional social phenomena. The particular ways in which different types of data were combined in this study to achieve a multi-dimensional view of TW are discussed in more detail in relation to the study design below.

5.3.2 The iterative use of theory

This study was informed by grounded theory. Glaser and Strauss's (1967, p. vii) ideas about grounded theory were seminal in the advancement of qualitative research in that they helped to "close the gap" between theory and empirical research through the development of methods that enabled researchers to build theories about social phenomena directly from the data that they generate. More usually aligned with an inductive approach to research, qualitative research offers an opportunity to explore social phenomena from new perspectives, moving beyond the confines of existing social theory. One of the strengths of a grounded theory approach is that it increases the likelihood that findings derived reflect the social phenomenon under scrutiny as the concerns of participants inform the direction of the research (Strauss & Corbin, 1998). As part of this process, concepts and themes emerging as important from the data are developed into a more meaningful interpretation of events (Bryman, 2008). The approach is particularly suitable for an exploratory study such as this one as it enables the identification of salient aspects of ABI processes by the actors involved. As there is little understanding about the ways in which an ABI might influence change, exploring the perceptions of people involved with and affected by a particular ABI provides an opportunity to develop new theoretical insights into how activity unfolds over time.

Categorisation of qualitative research as solely inductive can be misleading however (Bartlett & Payne, 1997) and as philosophers of science have argued (see for example Popper, 1959), all scientific research involves processes of deduction

(using theory to develop hypotheses) and induction (theory development from empirical findings). Theory generated through qualitative research process is always tested to validate findings, a method that helps to achieve results that are grounded in the data (Glaser & Strauss, 1967). In most quantitative research deductive reasoning is used to develop a hypothesis which is then tested (Bryman, 2008). Data are used to assess the extent to which the hypothesis holds true – refuting, confirming or refining a hypothesis inductively from the data. Inductive and deductive processes therefore are most usefully described as operating at different stages of the research process in qualitative and quantitative research. This raises particular issues regarding the role of theory in a mixed-methods study, one of which is the extent to which research should be informed by existing theory.

In their original introduction to grounded theory ideas, Glaser and Strauss (1967, p. 33) argued that researchers should approach empirical research without reference to "preconceived theory" to prevent empirical data being forced into existing substantive theories. This reflects, according to Dunne (2011, p. 114) a "desire to allow [explanatory] categories to emerge naturally from the empirical data during analysis, uninhibited by extant theoretical frameworks and associated hypotheses". As others (Dunne, 2011; Elias, 1978; Strauss & Corbin, 1998) have argued, it is impossible for researchers to generate data uninformed by existing theory. Challenging a dichotomous view of inductive and deductive approaches, Elias (1978, p. 35) claimed that scientific development depends on endeavours which combine interpretation and observation: the two elements being "indivisible" as observations are needed to construct theories and vice versa. Therefore, while qualitative researchers might seek to generate new theory, they are inevitably informed by existing ideas and theory with which they are familiar.

There are strong arguments for developing familiarisation with theoretical concepts before embarking on empirical research. For example, Bartlett and Payne (1997) describe the ways in which theoretical sensitivity encourages open mindedness in relation to data that can challenge researcher assumptions about a phenomenon. Pawson and Tilley (1997) argue that theoretical explanations for phenomena have their origins in the design stage of a research project in that the study design shapes the findings that are generated. Engaging with existing ideas in the design phase of a study encourages reflexivity towards the design process. A substantial part of the literature review presented in the previous chapter was completed at the beginning of the research process in order to identify areas where the study could

make a new contribution to knowledge in this field. The gaps in understanding that emerged from this review were used to inform the research design. In this respect, the literature review helped to establish the intellectual context for the study, positioning it in relation to what had gone before by identifying the issues of contention in the field and the gaps in current knowledge (Bourner, 1996). Substantive theory therefore informed the way in which the research problems were conceptualised.

The review also indicated that figurational ideas might provide some insight into ABI processes and these ideas were used to frame the study. Figurational sociology provides a set of ideas, including figuration, established-outsiders and habitus, that were used to frame the research questions and analysis. These ideas were used as "sensitizing concepts" to inform the study (Blumer, 1954, p. 7). Discussing the relationship between grand theory and substantive theory, Blumer argued that abstract sociological concepts, such as those discussed in the previous chapter, have less explanatory power in empirical situations than definitive concepts derived directly from the data.

> A definitive concept refers precisely to what is common to a class of objects by the aid of a clear definition in terms of attributes or fixed bench marks. This definition, or the bench marks, serve as a means of clearly identifying the individual instance of the class and the make-up of that instance that is covered by the concept. A sensitising concept lacks such specification of attributes or bench marks and consequently it does not enable the user to move directly to the instance and its relevant content. Instead it gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitising concepts merely suggest directions along which to look. (Blumer, 1954, p. 7).

Grounded theory and figurational ideas were blended by working both inductively and deductively to produce a more valid theory of the unfolding social dynamics of TW. In response to new ideas that emerged through data generation and analysis, additional literature was sought and reviewed throughout the research process. This provided an opportunity to explore potential explanations for the data that were emerging from the study. The work of Glaser and Strauss (1967) and later Stauss and Corbin (1998) helped to achieve greater credibility for qualitative research by demonstrating the need for different measures by which to judge the quality of its findings. By describing processes through which findings could be grounded in the data, the authors were able to demonstrate that the key test of qualitative research

lies in the clarity of the explanatory categories developed and their applicability to social experience. Quantitative data were used in this study to develop a description of the context in which TW unfolded and to test out emerging explanations for the qualitative data. For example, emerging ideas about the ways in relations between people in the case study unfolded were compared against intervention participation data and snapshots of collaborative relations in order to test their ability to explain the data.

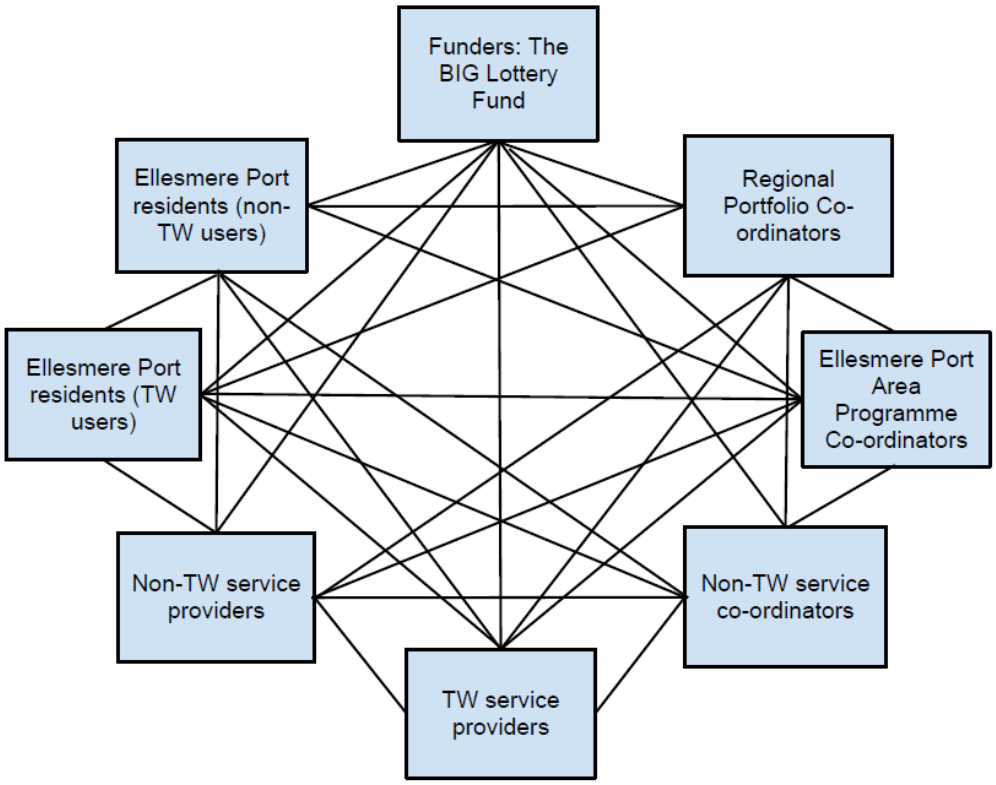
5.4 Exploring interdependent relations: a case study design

The research was conducted within the methodological framework of a case study. Case studies are typically used to explore social phenomena in their real-life context as they allow researchers to explore contextual conditions that may be pertinent to it (Yin, 2003). In this respect, the study aimed to examine the social context in which TW was implemented, not as a backdrop to the intervention, but rather to explain how the particularity of the context shaped the way in which it developed. Tellis (1997) argues that it is important to identify the parameters of the case study in order to capture salient features that might explain the phenomenon under examination. The Ellesmere Port TW programme constituted the unit of analysis. The programme was conceptualised as a figuration of interdependent people, and in this respect, it was understood to represent a dynamic network of people who were simultaneously interdependent with a range of other groups and people both inside and outside of the town. The Ellesmere Port TW programme was targeted at people living in the most socio-economically deprived postcode areas of the town and was designed to influence relations between residents and local service providers in those areas (Ellesmere Port co-ordinators, personal communication, February 2007). As such, the case study was focussed on interaction between people living and working in the areas targeted by the initiative.

Interdependencies between these groups and people living and working outside of the area were anticipated to shape the ways in which the initiative unfolded. Consequently, processes involving people living and working outside of the town, which might have been pertinent to understanding the development of the initiative, were also considered in the research. In line with a grounded theory approach, the parameters of the case were thus defined in relation to events emerging as important from the data. As the research unfolded therefore, particular figurations embedded within the Ellesmere Port programme were identified as salient to the

study. The networks that were of particular interest to this research can be defined as follows. First, there were groups of local residents (TW users and 'non-users', or residents who did not participate in any TW activities). Second, there were groups of service providers working at an operational level in either the delivery of TW services (TW providers) or other services in the town in the VCS and the statutory sector (non-TW providers). Third, there were groups of service co-ordinators working at a strategic level to co-ordinate TW either across the North West region (regional portfolio co-ordinators) or in Ellesmere Port (Ellesmere Port area programme co-ordinators). There were also people involved in the co-ordination of non-TW services in Ellesmere Port (non-TW co-ordinators). Finally, there were was a group of people who had funded TW at the BIG Lottery. The Ellesmere Port programme figuration that formed the basis for the case study is depicted in Figure 5.1. This diagram shows the smaller networks of interdependent people that made up the programme figuration and show how these different networks were interrelated.

Figure 5.1 The Ellesmere Port Target Wellbeing figuration



Case studies provide a way of studying a social setting as a set of social relationships, so that people are viewed “relationally” rather than as “atomised people” (Mitchell, 1983, p. 192). This makes it possible to focus on the patterns of relationships, interdependencies and interactions between the different people within the specific context of the case (Dopson, 2003). As ABIs necessarily involve the participation of a range of people, the case study approach offers the opportunity to investigate different interpretations of events (Keen & Packwood, 1995). By exploring multiple sources of information and converging lines of enquiry, a range of historical predispositions and actions can be explored (Yin, 2003) which might shape the ways in which ABIs develop.

Case studies are typically concerned with the particular complexities of a specific case in order to explain how social phenomena develop over time (Bryman, 2008). For this reason, it has been noted that case studies are potentially valuable for studying policy implementation and its consequences, particularly in terms of understanding why and how initiatives work within specific contexts (Dopson, 2003; Judge & Bauld, 2001; Keen & Packwood, 1995). As such the design is appropriate for exploration of the way in which an initiative is played out locally. The development of the initiative was followed prospectively from the first few months of project delivery until the completion of the funding period. This provided an opportunity to examine the ways in which relations in the case study area unfolded over time. This study design therefore reflected a conceptualisation of an ABI as a series of interconnected social processes. Examining social processes prospectively, and thus developmentally, has the potential to better explain unplanned events as set of events that are linked through time (Mitchell, 1983). As (Maguire, 1988, p. 192) argues, “analysing the significance which specific events have in time” provides an opportunity to explain their connections.

As Yin (2003) notes, case studies are often criticised for having poor external validity as it is argued that the particulars of one case cannot be considered representative of others. Mitchell (1983) argues, however, that the internal validity of the findings is more important for generalisation from case studies. In this respect, case studies are usually concerned with generalisation through theoretical insight rather than through statistical representativeness (Yin, 2003). By looking in detail at the particular nuances of one case, researchers hope to identify factors that might influence the phenomena in other settings (Gibbs, 2007). Mason (2006) suggests that by identifying the salient elements of a particular context qualitative researchers

can articulate the principles governing a particular phenomenon. The quality of case study research is therefore judged by considering how well the specifics of the case relate to the theory that has been generated (Bryman, 2008).

5.5 Ethnographic methods

The study made use of ethnographic methods to explore how TW unfolded. The term 'ethnography' describes a particular approach to studying social phenomena and refers to both the methods used in research as well as to the product of the research (Angrosino, 2007; Bryman, 2008). Ethnographers are typically concerned with exploring the social relations, beliefs and values of a particular community (Angrosino, 2007) and seek to present an account of the people studied through their own eyes (Bryman, 2008). For these reasons, ethnographic research takes place in natural settings and requires the researcher to immerse him or herself in the setting for extended periods of time (Bryman, 2008). Immersion within a social setting enables researchers to take account of the full social context of events (Mulhall, 2003) and is therefore useful for exploratory research as it enables researchers to study phenomena from several different dimensions (Angrosino, 2007).

Ethnographic methods are particularly useful for documenting a social process, as immersion in the social context in which the process takes place will enable the researcher to take account of unanticipated outcomes and the dynamic nature of any social setting (Angrosino, 2007). As this research sought to explore the processes, networks and pathways that mediate a planned public health development, ethnographic methods enabled the development of the initiative to be traced over time, exploring any unintended consequences. This offers the potential to explore people's points of view from within the context of their social relations. As it is theorised that their views will be informed by their connections with other people, it follows that speaking to people in a social setting will provide insight into how the ways in which their relations to others shape their views. Data generated through the case study were therefore located in relation to the dynamic place in the local network occupied by participants. Elias and Scotson (1965, p. 10) argued the importance of context for understanding social phenomena, reasoning that "every element of a configuration and its properties are what they are only by virtue of their position and function within a figuration".

Given their emphasises on the role that research participants play in the construction of a social reality, ethnographic methods are aligned with interpretivist perspectives (Mulhall, 2003). Ethnographic methods require particular attention to a second layer of interpretation that occurs in the development of interpretive accounts, that undertaken by the researcher (Shutz, 1962). In any qualitative study, care is needed to ensure that the researcher's own frame of reference (his or her preconceptions and ways of viewing the world) does not unduly influence the research; findings should reflect the perspectives of participants as closely as possible. This requirement is particularly relevant to sociological enquiry given that researchers are unable to completely disentangle themselves from the world that they study (Smith, 2002).

Elias (1991) has argued that debates about objectivity and subjectivity might more adequately be conceptualised as the degree to which researchers are emotionally involved in the subjects that they study. He argued that the most adequate accounts of social phenomena might be developed through balancing emotional involvement with emotional detachment from the objects of social research. There is a particular risk in ethnographic research that the researcher might become embroiled in the concerns of the group and become unable to achieve the degree of detachment necessary to interpret the wider consequences of observed events (Hobbs, 1988). Elias (1987) argued that complete detachment from the phenomenon under scrutiny however is similarly undesirable and, more importantly, unrealistic. In order to achieve a deeper understanding of social life, it is necessary for the researcher to use his or her knowledge from human experience to interpret what she or he observes. This differentiates the role of the social researcher from that of natural science researchers, as Elias explained:

> "…while one need not know, in order to understand the structure of molecules, what it feels like to be one of its atoms, in order to understand the functioning of human groups one needs to know, as it were, from the inside how human beings experience their own and other groups, and one cannot know without active participation and involvement." (Elias, 1987, p. 14).

Waddington (2000) argues that researchers should adopt a relatively detached approach to the research process, setting aside personal concerns for the duration of the research. In this study, on-going discussion with the supervision team throughout the research process encouraged a greater degree of detachment from the subject of the topic under examination (Perry, Thurston, & Green, 2004). A field

diary was also kept throughout the period of data generation in order to record the researcher's responses to events in the field, which encouraged greater reflexivity with regards to the lines of enquiry that were developed (Bryman, 2008).

Ethnographic methods raise particular ethical concerns given that the level of social interaction between researchers and participants is greater than with some other methods. As ethnography requires access to a natural social setting, it is difficult to identify the people and events that might be observed during the course of the research at the outset (Mulhall, 2003). To respect the autonomy of potential research participants, consent for observations was managed on an on-going basis throughout the research. Access to individual project activities was negotiated on an on-going basis with staff in order to provide an opportunity for staff to withdraw from the research process.

The greater degree of control that the researcher tends to have over the research process can leave participants vulnerable to exploitation from researchers (Eide & Kahn, 2008). The ethnographic methods in this study, for example, required the on-going co-operation of TW providers over a 24 month period. One of the ways in which the imbalance of power in the research process was addressed was through adoption of participatory methods, which emphasise the involvement of research participants in the design and direction of a study (Cornwell & Jewkes, 1995). One of the key informants in the study, involved in the management of the initiative, was involved in the development of the research proposal and acted as a non-academic supervisor to the study. In addition, the researcher discussed the research design, methods and progress with staff at monthly meetings, during which staff were asked to provide feedback on the research process and to comment on the adequacy of emerging explanations for the ways in which the initiative was developing. This improved the likelihood that the concerns of providers and co-ordinators involved in the ABI would be addressed in the study, making the research more useful to the concerns of provider participants and improving the validity of the research (Chappell, 2000; Thornton, Edwards, & Elwyn, 2003; Truman & Raine, 2001). One of the disadvantages of using participatory methods in this way was that the balance between involvement and detachment was shifted towards participants with an emotional investment in the outcomes of the research. Maintaining a balance between the concerns of the research participants and sufficient detachment to identify events and participants that might be significant in explaining the processes through which ABIs develop was a constant challenge.

The involvement of residents in the design of the research might also have improved the relevance of the research to people targeted by ABIs but, given the limited time and resources available for the project, the opportunities for consultation with members of the public were limited. Although the ethnographic elements of the study required less involvement from residents, resident participants were in some ways potentially more vulnerable to psychological harm through participation in the research given their disadvantaged socio-economic position, experiences of physical or mental ill-health or long-term unemployment. The researcher recruited several participants to the study who had, or still were, experiencing severe and enduring mental health problems. In line with the principle of non-maleficence, the researcher's first objective was to ensure that the research process was a safe and enjoyable experience for all participants. The likelihood of this was improved through developing knowledge about the targeted community (Kavanaugh, Moro, Savage, & Mehendale, 2006) through a process of familiarisation with the case study figuration. Spending six months in the field prior to data collection produced insight into the behaviour of particular groups in certain settings. This process informed the way in which the study was designed. Spending time in mental health project settings informed the decision to involve project facilitators in the recruitment of participants with long-term mental health problems. The sampling approach used in the study in relation to non-participant observation, documentary analysis and qualitative interviews, is described below.

5.5.1 Theoretically-driven sampling

Sampling in qualitative research is a process that enables the researcher to include a range of relevant contexts or scenarios that might shed led on the phenomena under study (Mason, 2002). Events and activities were purposively and progressively sampled for observations and people identified for interviews according to the potential they afforded to explore the research questions. Purposive sampling is a deliberately non−random approach to participant selection whereby informants are strategically identified according to the likelihood that they will enable the researcher to explore the relevant research questions (Bryman, 2008). The findings from the early stages of the literature review drove this process in the first instance. For example, the initial review of the literature suggested that the size and scope of the organisation in which providers worked might influence relations with other providers within an ABI. Consequently, activities involving providers from a range of organisations varying in size and scope were observed to compare experiences. Subsequently, events were identified that might facilitate

development of emerging theoretical explanations, either by supporting or challenging emerging explanations. For example, through early discussions with non-TW service co-ordinators in the field a tentative theory was developed that structural reorganisations in the local authority and PCT had limited the extent to which staff there engaged with TW plans and activities. A decision was made to attend and observe a local area-partnership board meeting to examine the ways in which the initiative was discussed in strategic local planning, if at all. In this respect, the observations became “progressively focussed on key analytic ideas” (Charmaz, 2006, p. 22).

As the aim of the study was to uncover views that help to explain how ABIs develop rather than the prevalence of particular views, statistical sampling logic was inappropriate in determining the appropriate sample size for the study (Yin, 2003). Rather, in line with a grounded theory approach, a theoretical sampling approach was used. With this approach sampling becomes a non-discrete process as participants are identified for recruitment on an on-going basis according to the concepts and theory emerging from existing data (Bryman, 2008). The objective of this sampling method is to include “as many of the factors as possible” that might affect the phenomenon under scrutiny (Mays & Pope, 2000, p. 52). In this way, participants are recruited according to criteria that facilitate the development and testing of a theory about the phenomenon under scrutiny (Mason, 2002).

A systematic approach was used to devise a sampling frame. A grid was developed part-way through the fieldwork with information about how people in the figuration might help to answer the research questions. These grids were used to assess the information already collated and to set out what other information was needed, reflecting on the analysis process as Mason (2002) suggests. Consistent with a figurational perspective, sampling focussed on the ways in which events and participants were related to one another. Some providers, for example, were linked through close working while others had been identified as potential partners but links had not been established. Including these relations in the sample provided the potential to consider how relationships between these providers influenced the development of the initiative.

Diversity was sought in the sample according to issues that arose as significant. Initial analysis indicated that the type of activities delivered by providers impacted on the ways in which they developed relations with local people. Providers sampled

for interview therefore worked towards all of the TW themes: healthy eating, physical activity and mental health. The target audience of the projects also appeared to impact on the way in which projects developed, so projects working with working-age adults, older adults, and children were all included for a follow up interview. Sampling was also influenced by the apparent success of projects in engaging beneficiaries. The sample included providers who had exceeded recruitment targets as well as projects experiencing difficulty with recruitment. It also became apparent early in the research that the Eliasian concept of 'established and outsiders' might provide a useful sensitising concept with which to explore project experiences. Distinctions between 'local' and 'outside' delivery organisations were made by several local service providers in early interviews. The researcher therefore endeavoured to include for a second interview, TW providers who had no experience of working in the area prior to the initiative as well as staff who had worked in the area before. In addition, the issue of 'social exclusion' emerged as an important concept through which local social interaction within the initiative might be understood. Providers targeting groups perceived to be at risk of social exclusion including older people, people with mental health difficulties and people who were unemployed (particularly lone parents) were therefore recruited for a second interview. This presented a good opportunity to explore how social interaction might be changed through TW. In this respect, certain events and situations were selected for further scrutiny as the researcher determined them to be relevant to her explanations (Mason, 2002).

Local residents were purposively sampled using a variety of methods. TW users were identified through discussion with TW providers. The service-user database, established as part of the monitoring and evaluation arrangements for the initiative was also used to devise a resident stamping frame. The database was interrogated to identify male and female participants from a range of age groups, ethnic backgrounds and areas of residence. These characteristics were considered relevant to understanding relations with TW providers, who reported differences with regards to activity participation according to these categories. This was supported by information recorded on the TW database. The researcher also tried to ensure diversity in the sample with regard to the extent to which residents had engaged with the project. These differences enabled the researcher to explore aspects of participation in the context of a range of different life experiences (Mason, 2002).

In line with a grounded theory approach, data generation through ethnographic methods continued until saturation of theoretical categories was deemed to have been achieved (Glaser & Strauss, 1967). Assessing when saturation has been achieve is difficult to define (Baker & Edwards, 2012). The amount of data generated was deemed sufficient once no new ideas were being generated from interviews and observations which challenged or refined the explanations developed from the data and the explanatory concepts, as well as the relationships between them, were considered sound (Strauss & Corbin, 1998). In this respect, saturation was determined by the quality of the analysis that was emerging in terms of its depth and explanatory capacity. In an interview for the National Centre for Research Methods (Baker & Edwards, 2012, p. 5), Mason argues that there is a "need within qualitative research to build a convincing analytical narrative based on 'richness, complexity and detail' rather than on statistical logic". As with most qualitative studies (Baker & Edwards, 2012), there was also a practical need to limit the amount of data generated according to the resources available for thorough analysis and writing up. Although the data analysis process was started while still in the field, there was a need to draw the fieldwork to a close while data analysis was on-going in order to have sufficient time to develop the analysis. In some instances, generating more data might have benefitted the categories but this did not become apparent until the analysis was complete. By stepping away from the field, there was also the possibility that important events in the development of the initiative were missed. This was managed to some degree by retaining contact with key informants to maintain a view of developments over time. Quarterly programme meetings were attended until they ceased.

Repeated observations, supplemented with informal and formal interviews, enabled comparison between participants' accounts of their own behaviour with what they actually did (Mulhall, 2003); or, as Angrosino (2007) notes, to compare ideal behaviours with actual behaviours. Triangulation was used, therefore, not to establish the 'correct' data, but rather to compare different perspectives (Mulhall, 2003). One of the ways in which validity can be improved in qualitative research is through participant validation of findings (Mays & Pope, 2000). This process involves exploring the extent to which participants corroborate the account generated by researchers in their analysis of qualitative data (Mays & Pope, 2000). Presenting emergent findings to TW providers provided an opportunity to examine the extent to which participants recognised the account generated by the researcher and to incorporate their responses to the findings as new data (Mays & Pope,

2000). In addition to the formal observation schedule, field notes were kept throughout the period of data generation. This provided a way of capturing information and impressions generated by informal conversations during chance encounters and telephone conversations with staff.

5.5.2 Non-participant observation

Non-participant observation was conducted across a range of activities in the case study area over the course of 27 months. Non-participant observation provides an opportunity to learn about social phenomena through immersion in the on-going activities of people in their everyday setting (Angrosino, 2007). Patterns of interaction between people in the case study setting were observed through these methods (Quinn Patton, 2002) enabling the development of explanations about behaviours that were grounded in the context in which they took place. Non-participant observation enables the researcher to retain a level of detachment necessary for observing patterns of behaviour, while simultaneously cultivating a good rapport with participants through some degree of social interaction (Angrosino, 2007). The approach taken in this study sat somewhere in the middle of Gold's (1958) scale of researcher involvement. Gold (1958, p. 222) identifies extremes of complete researcher detachment, that might be cultivated through covert methods, and complete researcher participation, or "going native". These methods enabled a balance to be maintained between involvement and detachment, gaining access to 'in vivo' ways of knowing while maintaining a wider perspective on events, making detached observations from within the cultural setting under study (Angrosino, 2007). The type of activities observed, and the ways in which access was negotiated are discussed in more detail below. Fifty two formal observation sessions were carried out in addition to less structured observations that arose from immersion in the TW figuration. A full list of observation activities is shown in Appendix 2.

It was necessary to obtain endorsement for the research from the regional support network staff, given their role in managing the portfolio on behalf of the BIG Lottery. Although the research had been approved in principle by the portfolio steering group prior to the researcher's appointment, it was necessary to establish support for the specific approaches employed in the research from those people involved in the day-to-day management of the initiative. The researcher was introduced to the Portfolio Manager via the Ellesmere Port Programme Manager and the three

members of the support network during the first week of the research project. Through open discussion about the research objectives, as well as the ways in which data would be collected, the researcher was able to develop rapport with the co-ordinators, who expressed a desire to learn as much as possible about the initiative through research and evaluation.

At the regional, portfolio level, meetings between TW co-ordinators were observed, including a number of the quarterly meetings held among programme managers and a number of meetings of the portfolio evaluators. These observations provided an opportunity to examine the ways in which co-ordinators related to one another and the ways in which the strategy for the initiative was developed and managed through these relations. Through spending time in the field, opportunities emerged for informal discussions (Bryman, 2008) with co-ordinators in and around meetings. These discussions often elicited opinions not expressed in more formal settings, such as meetings. Information sheets about the purpose of the observations (shown in Appendix 3) were given to TW co-ordinators once ethical approval for the study had been obtained. Consent to observe was obtained verbally from staff and invitation to observe additional activities was taken to indicate on-going support for the research on the part of people. Given the large number of people involved in some meetings, and the unpredictability of attendance, it was not always practical to provide information sheets to attending non-TW co-ordinators. Instead, the researcher's role was explained verbally by the Meeting Chair and attendees were invited to raise questions or objections. Balancing the need to minimise inconvenience to observed participants with the need for clear and transparent information about the purpose of the research (Angrosino, 2007) was a constant challenge throughout the fieldwork.

At the Ellesmere Port programme level, quarterly programme meetings presented an opportunity to observe relations between TW providers and local TW co-ordinators. Fourteen quarterly programme meetings were observed in total. TW providers were also brought together at a number of promotional and training events. These events provided an opportunity for the researcher to observe the providers working together with the public. The researcher was first introduced to TW providers at the second Ellesmere Port Programme meeting, immediately after appointment. The researcher was then introduced in person to TW providers on a one-to-one basis via the Programme Manager. These early meetings, along with the documentary analysis described below, enabled the researcher to become familiar

with the aims and activities of each project. Following ethical approval for the study, the research questions and methods were explained in more detail at a programme meeting and providers were given the opportunity to ask questions. Participant information sheets were disseminated at this meeting and staff asked to give their verbal consent to be observed. Providers absent from the meeting, or other people identified as part of the figuration at a later date, were approached for consent on an individual basis as appropriate. Providers at all eight TW projects consented to be observed. Local residents at observation sessions were informed verbally of the researcher's presence and participant information sheets were made available. Residents were then given the opportunity to raise questions or concerns with the activity facilitator. Several activities involved observation of children in a primary school setting. In these instances, verbal consent to observe was sought from the appropriate member of staff as well as from the children themselves.

An observation schedule (Appendix 4) was devised to structure the information recorded at observation sessions. As Quinn Patton (2002) recommends, the schedule was devised to capture details about the setting of any activity, what took place, the people taking part, the perceptions of the activity from the point of view of the participants and the researcher's own impressions of events. As it was anticipated that several figurational concepts would inform understanding about the behaviour in relation to the initiative, the schedule was also informed by this theoretical perspective. For example, the schedule endeavoured to capture information about relationships between activity participants as well as any unplanned consequences of the activity. In line with a grounded theory approach, the schedule was adapted as field work progressed, in order to capture information relating to emerging lines of enquiry, such as relations between local and 'outsider' providers. By going back and forth between analysis and data generation, emerging explanations could be checked and refined (Charmaz, 2006).

5.5.3 Documentary analysis

As is typical of an ethnographic study (Bryman, 2008), non-participant observation was supplemented with interviews and documentary analysis in this research, enabling the researcher to gain a detailed view of developments within the initiative. Documentary analysis provided insight into the development of TW over time. Documents relating to the initiative and to service provision in the town more generally were sought in order to examine some of the ways in which information

about the initiative was communicated between co-ordinators and providers in the town and to residents targeted by the initiative. Documents relating to other service provision were sought to identify local priorities and service provision developments and to trace the impact that the initiative might have on other local events. Documents under the five broad areas listed below were considered relevant to the analysis and were included in the research when they were identified (a full list of documents included in the analysis is shown in Appendix 5):

- documents relating to the regional and local funding bid for the initiative;
- quarterly monitoring reports submitted by the individual projects in the local; programme to the funders throughout the duration of the initiative;
- agendas and minutes from monthly meetings between TW providers;
- TW publicity documents;
- E-mail communication between TW co-ordinators and TW providers sent via circulation lists;
- agendas and minutes from the local area partnership board;
- minutes from the local Community Sports Network meetings.

One of the benefits of using documentary analysis was that data in text format that were already produced could be accessed by the researcher with relative ease. This method can be relatively unobtrusive to participants (Bryman, 2008), although the retrieval of documents not in the public domain did require some work on the part of co-ordinators and providers to locate and them. Given that the co-ordinators and providers acted as gatekeepers to documents, it is possible that some documents might not have been made available to the researcher.

Documentary analysis was particularly helpful in the early stages of the research for background information on the initiative and its origins, helping to identify key people involved and information about the strategy of the initiative. Documents were used to inform the sampling frame for observations and interviews. For example, review of documents relating to the bid process revealed the names of people involved in commissioning services, some of whom were purposively sampled for interview. Documents were also a helpful way of exploring change over time. Some documents were produced at regular intervals throughout the initiative (for example, meeting minutes), making it possible to explore how issues discussed between providers changed over time. This was also facilitated by the fact that many of the

documents had a set format. For example, programme meetings had set agenda items. As quarterly reports completed at each project chronicled information under set headings, they were used to draw comparisons across projects.

As with any qualitative data source, care needs to be given to the reliability of accounts provided in written documents. Documents are written for a specific purpose and the author's agenda might not be easy to determine as he or she controls the information that is provided, without recourse to question (Bryman, 2008). Scott (1990, p. 6) points out that this can also make it difficult to determine the author's "meaning." One of the benefits of combining documentary analysis with other ethnographic methods is the opportunity afforded to triangulate findings with other data in order to pull out meaning. Certain inferences drawn from documents in this study could be followed up in interviews and observations (Yin, 2003). In this respect, the documents could be read with the context in which they were written in mind (Coffey & Atkinson, 1996), as background information was made available through other methods. For example, TW advertising materials were considered with reference to the aims set out in bid documents and compared against interview data to understand what message the providers were trying to convey to the public.

The use of documents that are available in the public domain raises few ethical issues. However, it was necessary to protect confidential information obtained from research participants, such as e-mail correspondence during fieldwork and to anonymise personal communications when writing up the research.

5.5.4 Qualitative interviews

Semi-structured interviews were conducted with residents, service providers and service co-ordinators to examine their perspectives on the initiative. Written consent was taken from all interview participants (see Appendix 6). Qualitative interviews are appropriate to an interpretive inquiry as they allow for in-depth exploration of experiences (Charmaz, 2006). Semi-structured interviews were particularly relevant to this study as they enabled participants to shape the topics and issues discussed within a framework created by the interviewer (Denscombe, 1998), encouraging participants to raise what was salient for them in the context of a broad framework of researcher interest. This enabled key processes related to ABIs to be uncovered from the point of view of participants. As other qualitative researchers have argued, narratives, which can be elicited through interviews, are "the medium through which

our understanding of the relationship between [different experiences] is expressed" (Popay, et al., 1998, p. 640).

Nine months into the research a series of semi-structured interviews was conducted with 29 providers, including TW providers at each of the eight projects in the programme and providers connected in a variety of different ways with one or more of these TW providers. The number of service co-ordinators and providers recruited to interviews is shown in Table 5.1. Providers at four out of the eight TW projects in the town were interviewed twice to explore changes to provider relations identified through observations and documentary analysis. Analysis indicated that the programme co-ordinator occupied a central position within the figuration of TW providers; consequently she was also interviewed twice to explore her perspective on change.

Table 5.1 Service co-ordinator and provider interviewees

Professional role of interview participant	Interview participant label	No. interviewed
Delivering TW activities within the town through face-to-face contact with residents	TW providers	15
Delivering services within the town that were not funded through TW (including statutory health services and private skills training)	Non-TW providers	4
Co-ordinating TW activities at a strategic level across the North West region (VCS representatives) or within the town (Primary Care Trust managers)	TW co-ordinators	5
Co-ordinating and supporting service provision within the town via VCS or statutory organisations (including local authority officers)	Non-TW co-ordinators	5
Total		**29**

The aim of interviews with service co-ordinator and providers was to encourage participants to provide in-depth accounts of their experiences of TW. This was achieved by asking opened ended questions and then probing for further information (Denscombe, 1998). In qualitative interviews data are generated

through the social interaction between participant and researcher (Bryman, 2008). The two-way nature of human conversation means that the researcher's probes and responses to the participant's speech will shape the data produced. Rapport established before the interview therefore influences the amount of trust that participants have in the interview. In provider and co-ordinator interviews rapport was built on existing relationship with participants, developed through time spent in the field during familiarisation and observations. Service co-ordinators and providers were invited to participate in a research interview by the researcher; non-TW providers were approached directly by the researcher or via the TW providers working with them, according to recommendation of TW providers. All participants were contacted by e-mail or telephone and were provided with an electronic or paper copy of the participant information sheet (shown in Appendix 7) prior to interview. Interviews were conducted in co-ordinators' and providers' place of work, with the exception of one TW co-ordinator who was interviewed at another service venue when visiting Ellesmere Port. This made it more likely that participants would feel at ease but the latter interview was potentially damaged by the presence of Ellesmere Port TW providers in the area immediately outside of the office where the interview took place. This reflected the difficulty of balancing convenience of the interview to participants with the need to create an environment which would be conducive to getting the most authentic data.

The insight gained into TW through time spent in the field made it easier to demonstrate an appreciation of the experiences during interviews. The rapport established through this time in the field facilitated the one-to-one interviews that followed. Field notes were used to inform the interview schedules, both in terms of the lines of enquiry to be explored and the tone of the questions. Ethnographic methods are particularly useful for sensitising the researcher to the cultural nuances of the people under study, enabling him or her to adapt research tools to suit the participants' preferences (Angrosino, 2007). For example, as the researcher was aware of some of the tensions between particular providers, such topics could be approached sensitively in interviews. As participants were aware that the interviewer would be present as an observer at future programme meetings and other events, this might have made some participants more reluctant to present controversial views that were potentially critical of other people in the figuration. Non-TW providers identified as partners by TW providers also perceived that the interviewer was closely associated with TW. This might have made 'partner' interviewees reluctant to criticise TW providers in some instances. These issues were partly

addressed by reminding participants about the confidentiality of the interview and showing discretion when interview participants asked what others had said during interviews.

Interviews with co-ordinators and providers took place over 12 months. Discussion focussed on the history of provider relations in the town, perceived balances of power between providers, processes through which providers worked together, and ways in which co-ordination between providers was perceived to influence service provision locally. Interviews were also used to examine the ways in which co-ordinators and providers made sense of what it means to live in Ellesmere Port, the ways in which they worked with residents and the consequences that they thought emerged for residents following participation in local services. An example of the interview schedules devised to guide discussion with co-ordinators and providers is shown in Appendix 8.

Twelve months into the research, residents were recruited for interview. TW users were recruited according to the advice from TW providers working with them. In most instances, this involved provision of an information sheet (shown in Appendix 9) by service providers and a request to pass contact details on to the researcher. Local residents who had not accessed TW activities were identified through a resident survey about TW conducted by undergraduate students at the University of Chester[1]. Survey respondents who had consented to be contacted via the details they had given, were approached and invited for interview. Two participants were recruited via this method. Another resident, who was known not to have participated in TW, was recruited through staff at the local PCT following his participation in a PCT-led community project. The number of residents recruited and their status as either 'TW users' or 'non-users' is shown in Table 5.2.

Interviews were conducted in locations chosen by resident participants, either their own homes or a room provided by a service they were using. Interviews with residents examined how it felt to live in Ellesmere Port, particularly in terms of relations with other residents and service providers. TW users were asked about their experience of TW projects. An example of the interview schedules used to guide discussions with residents is shown in Appendix 10.

[1] The survey was developed and conducted by students as part of an undergraduate module in research methods. The survey was designed to assess knowledge about TW among residents in Ellesmere Port. The sample size was considered to be too small to draw any conclusions.

Table 5.2 Resident interview participants

Social location of resident in relation to the initiative	Label	Number interviewed
Target Wellbeing users	TW user	9
Non-Target Wellbeing users	Non-TW user	5
Total		**14**

5.5.5 Quantitative methods

In order to trace the development of the initiative over time, quantitative data, routinely collected by each of the eight projects within the Ellesmere Port programme was interrogated. These data were recorded for the purposes of monitoring and evaluation at a portfolio level, as required by the funders. Details recorded included participant address, ethnicity, age group and sex. Following initial registration of a project participant, staff recorded the type of activities attended by participants and the number of attendances. This information was stored on an electronic database managed by the regional TW evaluation team. Before recording these data, TW providers obtained written permission from service-users to share these data with partner organisations for the purposes of research, which included the present study. While evaluation of service user characteristics was conducted at a programme level by the regional evaluation team, analyses were not conducted at project level. Analyses of these data in this study enabled examination of the characteristics of people engaging with individual projects, as well as overlap between projects.

Pre- and post-participation data relating to wellbeing and health behaviours were also captured as part of the regional evaluation. These data provided some insight into changes in residents' behaviour following participation in a project, which was used to inform the qualitative work.

5.6 Analysis: combining the case study data

Qualitative and quantitative data were combined in the analyses of data to form a comprehensive view of the ways in which TW unfolded over time. Unlike

quantitative methods, the procedures for qualitative data analysis are less clearly defined (Bryman, 2008). The quality and the accuracy of the findings produced in any qualitative study might only therefore be judged if a sufficient account is provided of the ways in which the data support the findings (Bartlett & Payne, 1997). Qualitative researchers often refer to a two stage process in the development of data analysis. The first stage requires a description of what is happening in the data: an account that reflects the rich detail of the data that might be developed into explanation at the second stage of analysis (Gibbs, 2007). These stages of analysis have been broken down further to provide a detailed account of the processes carried out. The ways in which quantitative data informed the analyses are also explained.

Informed by a grounded theory approach, the analysis of qualitative data was carried out in tandem with on-going fieldwork. Interviews were transcribed verbatim. The transcriber signed a confidentiality agreement in line with the requirements of the University's policy on ethical conduct. The transcripts were returned to the researcher within two weeks and, where possible, immediately checked for accuracy. The speed with which this was done was likely to make recall more accurate. However, fieldwork commitments made this difficult in many instances. These checks constituted the first stage of analysis as they allowed the researcher to become more familiar with the data in the context of the whole interview (Bryman, 2008). Subsequently, the transcripts were read in their entirety to develop familiarity with the data in their textual format. The transcripts were annotated during this process to identify possible categories and themes by which the data might be indexed at a later point in time (Pope, Ziebland, & Mays, 2000). The ideas developed during this first stage of analysis were considered to be tentative or emerging ideas that might provide indicators of concepts that would be developed at a later stage (Bryman, 2008).

Qualitative data were managed using NVivo software for qualitative analysis. Software of this type is essentially a tool to manage the large amount of data generated by qualitative research (Gibbs, 2007) and is not a substitute for researcher analysis (Bartlett & Payne, 1997; Pope, et al., 2000). The primary benefit of using software for data analysis is that it facilitates the process of organising data, ensuring that the first descriptive stage of analysis is completed in the systematic fashion required. Data of many different types can be stored in one place using the

software, enabling the researcher to move easily back and forth through the data during the coding process.

Following data familiarisation, and while fieldwork was on-going, the coding process was started. Coding builds the analytic frame that is used to interpret data (Charmaz, 2006). A selection of transcripts was initially coded line-by-line to encourage a critical perspective on the accounts and to ensure that initial ideas about the data were grounded in participants' accounts (Charmaz, 2006). Charmaz (2006, p. 48) has also argued that coding data according to actions "curbs conceptual leaps" that might be made using non-gerunds. Focussing on actions was particularly helpful in this study, which sought to identify the social processes through which ABIs developed. The order in which transcripts were selected for coding was determined by the potential for comparison across incidents as Bazeley (2007) suggests. For example, the first transcript coded unearthed a good deal of information about providers' 'use of volunteers'. To explore differences and similarities across organisations, a second transcript was selected where, from memory, no volunteers had been used. This was used to stimulate thinking about similarities and differences across different TW projects.

In order to manage the large number of codes generated by line-by-line coding, codes were compared and reorganised at repeated intervals while working through the transcripts. In this respect, coding gradually shifted onto a more abstracted level, once it was possible to be more confident about the information and ideas contained within the data. Bartlett & Payne (1997) suggest that coding can remain grounded in the data through systematic questioning; asking who, what, where, when and why in relation to particular statements to generate insight into what might be driving a particular account or perspective. Observation and documentary data provided contextual information at this point in the analysis in which the interview accounts could be situated. In this way, these data helped to clarify meaning in the accounts. Ideas about the ways in which emerging codes were related were recorded in memos (Charmaz, 2006). This ensured that ideas about the data were captured, without imposing them on the codes, which at this stage attempted to reflect the data as closely as possible. On-going discussion with the research supervisors throughout this process encouraged a greater degree of detachment from the data by challenging and questioning the emerging analysis (Perry, et al., 2004) and provided additional scrutiny in the development of codes (Mennell, 1992).

Following initial coding of a section of the data, connections between codes were explored in order to develop explanations about what was taking place. Through a gradual process of refinement, codes were merged or deconstructed into smaller components to form analytic concepts which sought to capture ways in which particular ideas and issues emerged in the data (Bartlett & Payne, 1997). This process was achieved through constant comparison across the data (Glaser & Strauss, 1967). Bartlet and Payne (1997) suggest that constant comparisons are used to verify the concepts under development and ensures that the emerging description of the data fits as closely as possible to as many of the cases in the data as possible. By moving back and forth through the data, findings that contradicted or supported emerging explanations were used to refine developing concepts so that they could "explain all or the vast majority of cases under scrutiny" (Mays & Pope, 2000, p. 51). Constant comparison of incidents across interview, observation and documentary data facilitated the synthesis of codes (Strauss & Corbin, 1998). For example, meetings between TW funded providers and providers rejected in their bid for TW funding could be examined through interviewee accounts, observed at meetings and examined through written correspondence.

Quantitative data were also useful in the development of explanations. Potential links between codes were tested against the 'story' told by the quantitative data. For example, a speculation derived from qualitative data that TW providers delivering activities from particular venues in the town had difficulty recruiting residents from target areas of the initiative was tested by examining the postcodes of service users at projects using different delivery venues. Postcode data were mapped using geographical information systems (GIS) software in order to examine the geographical spread of users and providers involved in TW. In this respect, different types of data were successfully merged to compare different dimensions of the same phenomenon (Creswell & Plano Clark, 2011).

NVivo facilitated the exploration of ideas at this stage of the coding process by enabling easy expansion or merging of codes with the option of easily reversing coding decisions that proved less useful. The software also helped to limit the risk associated with grounded theory of fragmenting the data. It is sometimes argued that by breaking down and separating aspects of the data, grounded theory risks losing the insight that can be gained through attention to complete interview narratives (Bryman, 2008). Using NVivo, coded text could be easily sourced to its original context, making it easier to analyse information with reference to the

structure of the narrative and social context in which it was produced (Pope, et al., 2000). Fragmentation of interview narratives was considered to be less problematic in this study given the focus within the design on social processes, rather than biographical accounts. For that reason, drawing comparisons across incidents and events was particularly important in this study, enabling a focus on relationships developed over time rather than on people.

Figurational ideas were used to sensitise the researcher to particular social processes taking place at every stage of the analysis. In this respect, a “constant interplay” was sought between generating new ideas directly from collated data and testing existing explanations of human actions (Elias, 1978, p. 34). Sensitising concepts were used to refine explanatory categories. For example, as discussed in Chapter 4, it was anticipated that the concept “established and outsiders” (Elias & Scotson, 1965, p. xv) might be useful in explaining partnership development. This concept had informed interviews and observations and was subsequently used to explore power balances between providers in the data. It became apparent through initial analysis that “knowledge of the local area” was important to TW providers and this idea was used as a category by which the data could be organised. Sensitivity to the idea of established and outsiders however, encouraged analytic attention on the ways in which local knowledge was used to influence relations between providers and to differences in the ways that providers defined local knowledge. Ultimately, as described in Chapter 8, it emerged that local knowledge was one of the ways in which ‘local status’ was cultivated among providers to control access to resources and this provided a valuable explanation for the ways in which partnerships developed.

5.6.1 Developing theoretical explanations

The analytic concepts developed through this process formed the basis for theoretical development as Charmaz outlines (2006). More abstracted definitions of categories were developed that sought to produce a “more precise understanding of the nature of the phenomenon” (Bartlett & Payne, 1997, p. 190). The concepts developed at this stage (for example, ‘organisational pull’) came out of the data but also reflected figurational sensitising concepts and theoretical orientation to the research questions. 'Organisational pull' reflected the ways in which providers described their affiliation to particular organisations but also reflected figurational ideas about the ways in which behaviour is constrained (or ‘pulled’) by particular

affiliations. This is explained more fully in Chapter 8 but this brief description explains how the analytic concept reflected the figurational orientation.

The categories developed were used as building blocks in the development of a theory (Charmaz, 2006). This stage of the analysis produced an in-depth description that reveals the complexity of the processes of partnership development and working with residents. The rich description of the data that was developed through concepts (Gibbs, 2007) was developed through further reorganisation of the data into distilled accounts that summarised experiences (Pope, et al., 2000). Ideas were tested out in the writing of the thesis. From here the researcher sought to integrate the theoretical analysis produced (Bartlett & Payne, 1997). This process involved the development of the main story that the research was able to tell (Charmaz, 2006). Cohesion in the theory was developed through identification of key concepts to which all others were related, as Bartlett & Payne (1997) suggest. The theory, or explanation, was then applied to all cases in the data in order to test its validity. In developing theoretical explanations, Bartlett and Payne (1997) suggest that the best fit for the highest number of cases in the data should be the aim. This process necessitated amendments to the theory in order to achieve this. For example, the significance of 'local' status to the development of provider partnerships in TW was established but application of this idea across the data indicated that the theory needed to be refined to explain why 'local' status became less relevant over time.

The aim of the analysis was to understand what people assumed to be real and explain how their actions were shaped by those interpretations (Charmaz, 2006). In this respect, the research sought to develop a credible account of the ways in which people constructed meaning and how they acted on it (Charmaz, 2006). Given the emphasis on theoretical explanations, qualitative data were used to illustrate explanations that, if not typical of the data set as a whole, had analytic value. The use of quotations and data in the accounts that follow are based on this understanding of the role of qualitative research.

5.7 Conclusion

This chapter set out the processes through which the research was conducted. The conceptualisation of the Ellesmere Port programme as a figuration of interdependent people influenced the decision to examine TW processes through a case study design. The following five chapters set out the findings that emerged

from the qualitative and quantitative data generated through the study. Substantive concepts are used to explain the ways in which TW unfolded over time and figurational ideas are used to explicate the meaning of the substantive concepts. To protect the anonymity of research participants in the accounts that follow, generic descriptions of projects are used when quoting providers and co-ordinators. As more than one resident was interviewed from the same project, making them harder to identify, specific project names are used to contextualise resident quotations. Pseudonyms are used when people are quoted directly.

Chapter 6

The social context for Target Wellbeing

6.1 Introduction

The purpose of this chapter is to describe the social context in which TW activities unfolded. The chapter is used to explore and account for the ways in which a range of people connected to the local Ellesmere Port figuration, including residents, service providers and service co-ordinators made sense of what it meant to live in the town. A historical perspective is taken in order to better understand the social conditions within the town that influenced residents' health. The chapter draws upon qualitative data generated through the study as well as publicly available data and documents relating to resident characteristics and service provision in the town. The chapter begins with a brief demographic profile of the town's residents, which is used to contextualise the following discussion about resident and service provider experiences in the town. A number of themes emerged from the analysis, which were used to explain local social developments; the second part of the chapter is organised by these ideas.

6.2 The local figuration: a demographic profile

Demographic information relating to the population of Ellesmere Port is used in this section to describe the social context within which the case study data were interpreted. Ellesmere Port is a town on the Wirral Peninsular in the north west of England situated between two cities, Liverpool and Chester. Figure 6.1 shows the geographical location of the town. The age and sex profile of the town's population during the period when TW was commissioned was similar to that for England as a whole, as Table 6.1 shows.

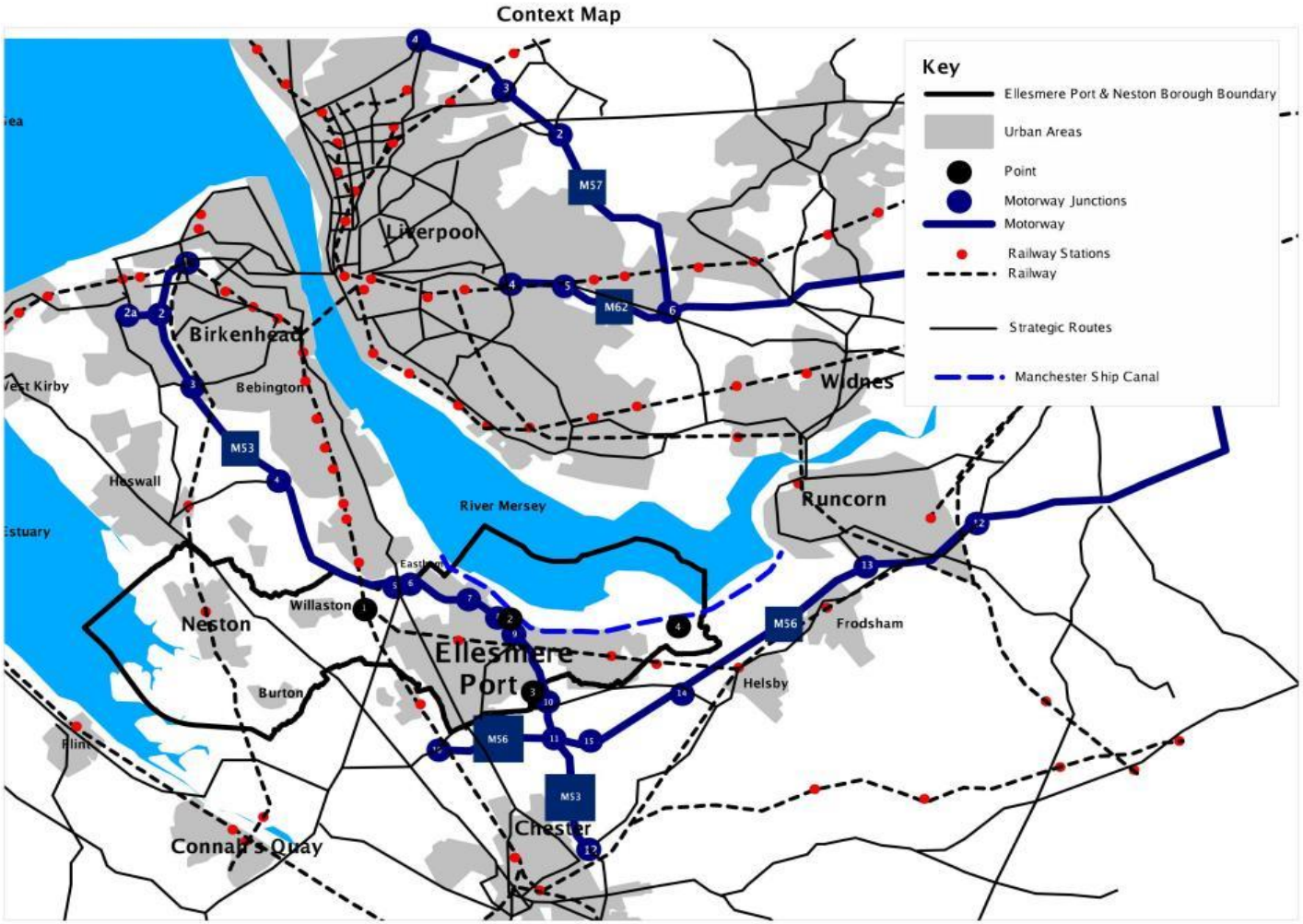


Figure 6.1 Geographical location of Ellesmere Port in the north west of England

Ellesmere Port's geographical position in relation to these two cities shaped economic and social conditions within the town and influenced the way in which residents thought about themselves and how they related to others. These themes will be examined in more detail later in the chapter, but it is worth mentioning here that, as Aspinall, Hudson and Lawton (1982) record, debate about whether Ellesmere Port should be aligned with Cheshire or Liverpool for administrative purposes had existed since the town's development in the 1830s. From 2009, the town had been positioned within the administrative borough of Cheshire West and Chester. Previously, the town had sat within the borough of Ellesmere Port and Neston, a smaller authority within which Ellesmere Port was the largest of two towns by some margin. Population estimates for 2007, when the TW bid was being co-ordinated, put the town's population at 61,171 in a borough of 81,000 (Office for National Statistics, 2010). When brought under the administration of Cheshire West and Chester unitary authority, as part of a local government reorganisation (LGR), Ellesmere Port was grouped with seven other large towns and the city of Chester, which in 2007 had an estimated population of just under 119,000 (Office for National Statistics, 2010). Ellesmere Port's alignment with a more affluent city for administrative purposes shaped the way in which local people felt about living there. This theme will be examined further later in the chapter.

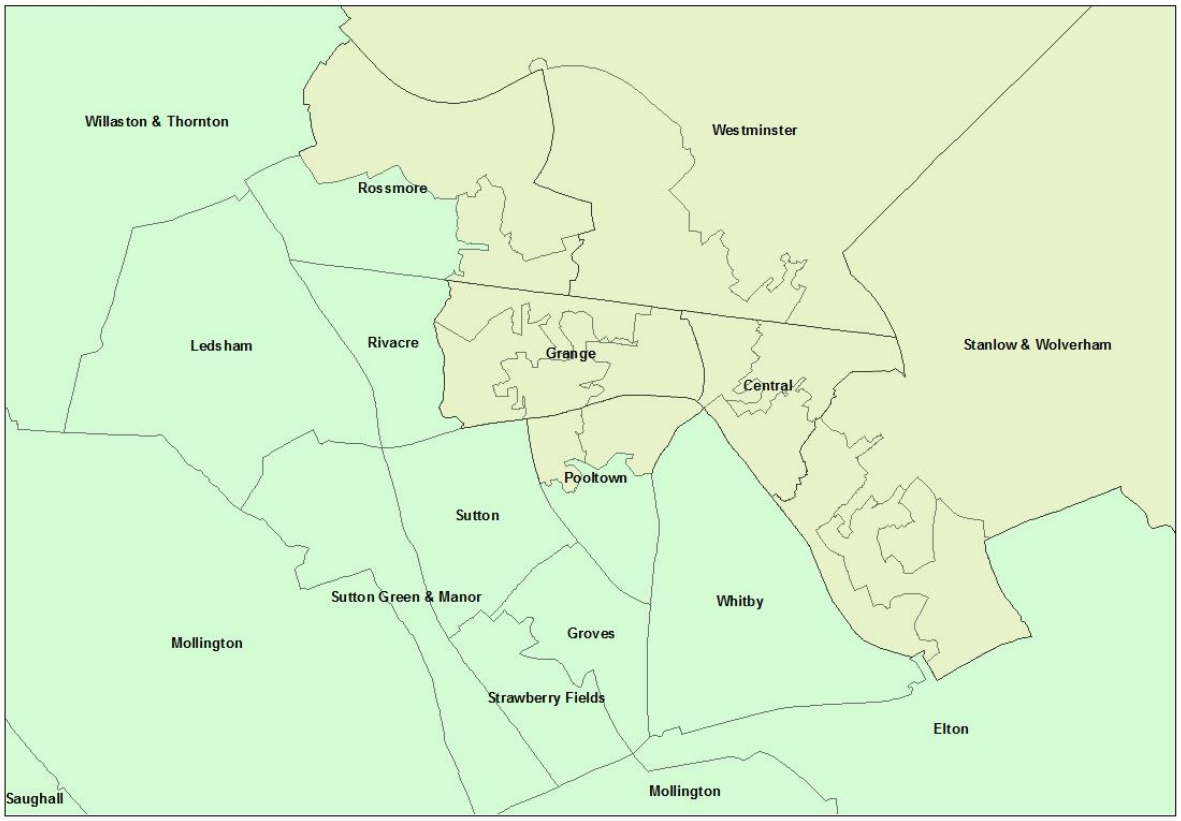
Table 6.1 Age and sex of Ellesmere Port residents in 2007

Age (Yrs)	Female thousands (%)		Male thousands (%)		Persons thousands (%)	
	Ellesmere Port	England	Ellesmere Port	England	Ellesmere Port	England
0-19	7.8 (23)	6,017.0 (23)	8.2 (28)	6,334.0 (25)	16.0 (26)	12,351.0 (24)
20-39	8.0 (24)	6,935.0 (27)	7.3 (24)	7,034.0 (28)	15.3 (24)	13,969.0 (27)
40-59	9.3 (28)	6,934.0 (26)	8.4 (28)	6,785.0 (27)	17.7 (28)	13,719.0 (27)
60-79	6.2 (20)	4,607.0 (18)	5.1 (17)	4,139.0 (17)	11.3 (18)	8,746.0 (17)
80+	1.6 (5)	1,494.0 (6)	0.8 (3)	826.0 (3)	2.5 (4)	2,320.0 (5)
All ages	**33.0 (100)**	**25,987.0 (100)**	**29.9 (100)**	**25,118.0 (100)**	**62.9 (100)**	**51,105.0 (100)**

(Office for National Statistics, 2010)

In 2007, Ellesmere Port was organised into 14 wards, the locations of which are shown in Figure 6.2. As described in Chapter 2, particular wards within the town were targeted by TW according to their level of health disadvantage. These wards are highlighted in Figure 6.2 in beige. Ward boundaries emerged as an influence on resident experiences of living in the town, as will be discussed later in the chapter.

Figure 6.2 Ward boundaries in Ellesmere Port in 2007



The population of each of the wards in Ellesmere Port is shown in Table 6.2. The TW target wards are shown in bold. The size of the wards varied from 3,580 to 6,360 residents. Differences across the wards in terms of measures of wellbeing are described in the section below.

Table 6.2 Population of Ellesmere Port by ward, 2007

Ward	Population
Central	**3,733**
Grange	**5,735**
Groves	3,513
Ledsham	5,836
Pooltown	**3,847**
Rivacre	**3,961**
Riverside	3,466
Rossmore	**5,832**
Stanlow & Wolverham	**5,711**
Strawberry Fields	3,592
Sutton	5,452
Sutton Green & Manor	4,019
Westminster	**3,580**
Whitby	6,360

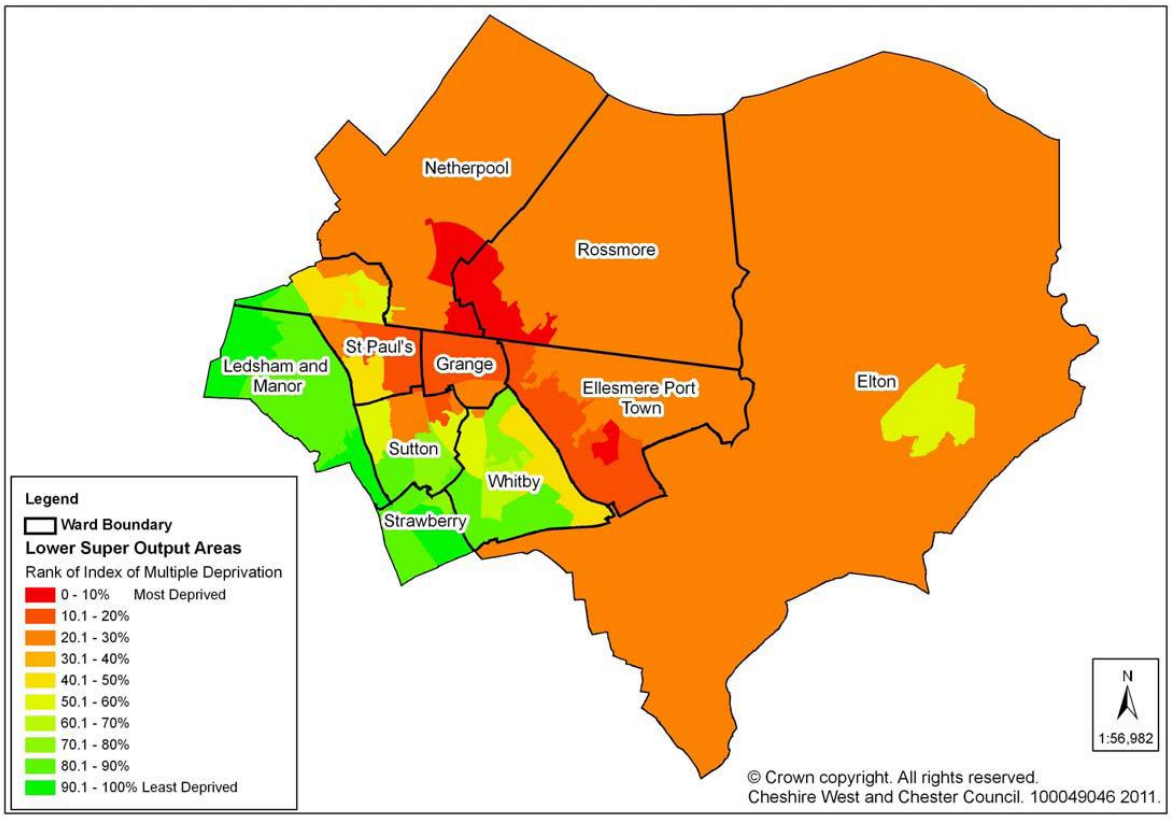
(Office for National Statistics, 2010**)**

6.2.1 Relative deprivation

Ellesmere Port was identified for TW funding on the basis that many of the wards in the town had lower levels of physical, economic and social wellbeing than other areas in the region. Data commonly used to measure wellbeing by the ONS, some of which were used in the identification of target areas by TW co-ordinators, are examined in more detail here. The IMD for England aggregate individual measures to estimate local area deprivation; they form the main source of deprivation measurement for the UK Government (Noble, McLennan, Wilkinson, Whitworth, & Barnes, 2008). Individual deprivation is measured across seven domains using a range of indicators largely based on routinely recorded government data, such as administrative records of benefit claimants within the income domain and certified causes of death within the health and disability domain (McLennan, Barnes, Noble, Davies, & Garratt, 2011). The 2010 IMD indicate that, in terms of overall deprivation, 12 LSOAs in Ellesmere Port fell within the 20% most deprived LSOAs in England;

four of which were within the 10% most deprived LSOAs in England (Communities and Local Government, 2010). All of these areas were targeted by TW. Figure 5.3 shows the 2007 deprivation ranking for LSOAs within Ellesmere Port. The wards labelled in the map reflect new boundaries since the town's integration into Cheshire West and Chester.

Figure 6.3 Indices of Multiple Deprivation ranking for 2007 for lower super output areas in Ellesmere Port



(Reproduced with the permission of Cheshire West and Chester Council)

A range of health outcomes for residents in Ellesmere Port compare unfavourably with national averages. Across the health and disability domain of the index of deprivation, 13 LSOAs within Ellesmere Port fell within the 20% most deprived in England in 2008; four of which were within the 10% most deprived (Communities and Local Government, 2010). For the period 2006-10, NHS Western Cheshire (2012) calculated life expectancy for men and women across Ellesmere Port as a whole (77.3 years and 81.3 years respectively) as similar to the English average (77.7 years and 81.9 years). Across the town however, there was variation in life

expectancy. For example, in Westminster and Central wards combined, this was 73.2 years for men and 76.9 years for women in comparison to 82.6 years and 83.4 years across Ledsham and Manor. In addition to shorter life expectancy in some areas of the town, there was a disproportionate burden of illness in some areas. In 2007, the main burden of ill-health in the town was accounted for by mental health problems, heart disease, stroke and cancers (Western Cheshire Primary Care Trust, 2007). The 2008 health profile for Ellesmere Port and Neston indicated that early deaths from cancer within the town were significantly worse than the average for England (Association of Public Health Observatories and Department of Health, 2008). Bone and joint problems and breathing problems were also prominent in the borough. For Ellesmere Port and Neston residents these have either caused a high number of early deaths and/or are estimated to cause a high number of years spent with ill-health (Western Cheshire Primary Care Trust, 2007). In 2008, 7% of people in Ellesmere Port were claiming Disability Living Allowance, compared to 5% across Cheshire West and Chester as a whole (Cheshire West and Chester Council, 2009a).

In terms of economic wellbeing, 12 LSOAs within the town fell into the 20% most deprived in England, three of which were in the bottom 10% (Communities and Local Government, 2010). As reported by the Research and Intelligence Unit at Cheshire West and Chester Council (2009a), the average household income across the town in 2008 was £32,700 which was 5% below the UK average and 9% below the average for the borough. Income levels were much lower in some wards during this period averaging £24,900 across Westminster, and £20,500 within one of the ward's LSOAs, some £12,200 lower than the town's average (Cheshire West and Chester Council, 2010). In terms of home ownership, a common indicator of economic wellbeing, differences existed across the town. Social housing within the town was concentrated within the target wards. According to Aspinall et al. (1982), a period of rapid housing development both within the private and public sector took place following the Second World War to deal with issues of overcrowding in the wake of a rapid expansion of industry in the town. As the council owned most of the land in the centre of the town, the majority of private housing was built on the periphery, influencing a geographical split between social and private housing. These differences in economic wellbeing across the town influenced residents' experiences of living in Ellesmere Port as will be discussed below.

Data on household structure can also be used to describe social circumstances which might impact on resident health. Census data from 2001 suggest that 27% of households in Ellesmere Port and Neston were occupied by a single person, compared with 30% across England and Wales (Cheshire West and Chester Council and NHS Western Cheshire, n.d). Some differences existed however across wards. Research carried out by the NWPHO provides some indication of differences in household structure between wards within the town. The research drew upon a commercial geo-demographic people classification tool which uses aggregate census data to categorise the populations of LSOAs (Beacon Dodsworth, 2009b). This classification method potentially obscures differences between households and people in an area and fails to capture the nuances of lived experience; however, it does provide some information about the circumstances in which many residents might have been living. The predominant classification for the Ellesmere Port wards targeted by TW was “urban producers” (NWPHO, personal communication 2007). According to the Beacon Dodsworth (2009a) classification, this group typically comprises residents aged 25-34 with children (often single parents) living in terraced council housing, often without central heating or gardens. People within these areas are likely to have few or no qualifications, low-paid routine or semi-routine occupations. Long-term unemployment and long-term illness are both highly likely within this group. Other areas within the TW boundary included ‘disadvantaged communities,’ ‘weathered communities’ and ‘urban challenge’ groups, which all have similar characteristics, the last two groups containing a higher number of pensioners. These data indicate that many residents in Ellesmere Port experience a number of material and environmental disadvantages which have been associated with poor health.

These types of comparative health and wellbeing data are routinely used to describe the residents of Ellesmere Port among service providers and in public documents. For example, the comparatively low levels of health and wellbeing in the town were used as an introduction in a variety of TW literature (TW co-ordinator, personal communication 2008; Target Wellbeing, n.d) as well as a range of other service reports relating to the town (Cheshire West and Chester Council, 2009a, 2010). Such data can be useful, as they have been here, in demonstrating some of the social and economic disadvantages, and their antecedents, which influence residents’ health. However, in isolation, these types of data provide only a partial description of residents’ lives, based on a discourse of disadvantage. The lived experience of these circumstances is interrogated in more detail below using

qualitative data generated through the case study. The ways in which the discourse of deprivation influenced residents' experiences of the town are examined in the first theme below.

6.3 Living on the periphery of a network

Residents' lives in Ellesmere Port were shaped by 'living on the periphery of a network'. This concept is used to explain how interdependencies between Ellesmere Port residents and wider figurations of people connected to nearby areas influenced residents' experiences of living in the town. The dimensions of this concept are discussed below.

6.3.1 Unravelling economic interdependencies

The concept 'unravelling economic interdependencies' reflects the way in which relations between residents in the town had changed over the last 50 years and how dependence on one another for employment and economic prosperity had reduced. The unravelling of economic interdependencies influenced the extent to which other figurations of interdependence, beyond the local town, influenced residents' lives. A brief description of how economic interdependencies were formed in the town helps to account for the impact of their declining significance. Resident and provider accounts of what it meant to live in Ellesmere Port had been formed over many generations and the town's social and economic history in particular had shaped relations in the town and experiences of living there. The economic success through which the town was formed, and its subsequent economic decline, were discourses that permeated definitions of life in Ellesmere Port. The town had developed through rapid economic success in the early nineteenth century when a canal port was opened on the edge of a rural settlement at the base of the Mersey estuary. The employment opportunities this created brought large numbers of settlers to the town: rapid population expansion was experienced during this period and again in the latter part of the century with the development of the Manchester Ship Canal in 1894 (Aspinall, et al., 1982). The port played an important role in the town's social development. The gateway that it created to the coast for North West and midlands trade attracted a range of manufacturers to the town, who could receive raw materials via the canal (Aspinall, et al., 1982). Iron and steel sheet industries, paper milling, cement and smelting industries and chemical manufacturing all thrived within Ellesmere Port before the First World War (Aspinall, et al., 1982; Northwest

Regional Development Agency, 2009). In the post-war years, the town experienced large shifts in its economic base but maintained its position as a large manufacturing base in the North West. The development of oil storage and refining capacity at Ellesmere Port in the 1930s created more employment opportunities for the town's residents: according to a local study by Brenikov (cited in Aspinall, et al., 1982), by 1950, almost 30% of the town's population were employed within the oil industry. In 1962, the Vauxhall Motors plant was opened in Ellesmere Port, which became a major employer of local people. Partly as a result of the abundance of manufacturing work, the rate of unemployment in Ellesmere Port was lower than the national average in the 1960s (Aspinall, et al., 1982). By 1976, manufacturing exports within Ellesmere Port exceeded those of Manchester (Northwest Regional Development Agency, 2009). For several generations, therefore, resident interdependencies had pivoted around industrial employment, a situation that would change towards of end of the twentieth century.

Reflecting a national decline in manufacturing, the 50 years prior to the case study had seen the closure of several of the town's largest employers (Ellesmere Port and Neston Borough Council, 2009). There was a 37% decline in manufacturing jobs in the town in the five years up to 2008 (Mickledore Ltd, 2011). At the start of 2008 the unemployment rate in Ellesmere Port was over 2.5%, compared to a Cheshire West and Chester average of less than 2% and a national average of 2.3%. (Cheshire West and Chester Council, 2009a). A breakdown of unemployment levels by ward during this period reveals variation across the town, with unemployment in the wards of Westminster, and Stanlow and Wolverham closer to 5% (Cheshire West and Chester Council, 2010). By the start of 2009, following the global financial crisis and subsequent UK recession, the unemployment rate in Ellesmere Port was 4.7%, compared to a borough average of 3.6% and an English average of 4% (Cheshire West and Chester Council, 2009a). Unemployment in Westminster ward by this time had reached over 10% (Cheshire West and Chester Council, 2010).

A discourse of decline emerged from interviews and documentary data which was related to the shift in the town's economic fortunes and in particular, the decline of manufacturing, around which the town had grown. The town's image as a regional industrial giant had become obsolete. Residents expressed a sense of pride in descriptions of the town's former industrial success. Older residents in particular were keen to describe how "thriving" the town had once been (TW user 09). The discourse of decline however, that residents perceived was perpetuated by others,

dominated accounts. The comments below from a resident in his 70s reflect how residents described local politicians' and service providers' attitudes to the town:

> A lot of [residents], they've got a disparaging view of where they live and okay, I understand that [Ellesmere Port] is somewhat a neglected area … There's a picture given out by some of the politicians that Ellesmere Port is a run-down area, Ellesmere Port is a town full of pound shops, you know … local politicians … they talk very disparagingly about Ellesmere Port. (Non-TW user 04).

The town's physical environment had developed around the manufacturing industry and there was a sense that, with the decline of these industries, the built environment no longer reflected residents' lives in the town. The existence of dormant industrial sites perpetuated a sense of lost identity. In the quotation below, a Council employee, who had worked in the town for over 10 years, describes how the visibility of redundant land in the town served to remind people of what he describes as a sudden demise of the town's industry:

> When the recession, in the 1980s restructuring came along, two thirds of the industrial and commercial land in Ellesmere Port went out of use, right. So if you look at that as a car accident, very few other towns suffered on that scale and the scars of that are still there and you can see them round the town, round the railway station, around the docks area … like Stanlow [oil refinery] that once upon a time employed … over 10,000 people. (Non-TW co-ordinator 05).

Residents and service co-ordinators perceived that derelict industrial sites in the town made it a less desirable place to live and visit. In a consultation document which set out the former Borough Council's plans for a regeneration of Ellesmere Port town centre, it was reported that derelict sites and vacant shops along one of the main roads into the town meant that "the first impression of most visitors to the central Ellesmere Port area is likely to be [of] a poor environment" (Ellesmere Port and Neston Borough Council, 2009, para. 2.29). One resident said that improving the appearance of these "waste areas" would make Ellesmere Port (often referred to as 'the Port') a nicer place to live:

> I think they could clean up the Port a bit more than what they do. As daft as it sounds, a few more flowers and things where they've got the wasted ground, you know, put a few flower pots or a little garden or something … just brighten the place up a little bit more, I suppose … there seems to be a lot of waste ground that's not particularly used for anything. (Non-TW user 01).

Unravelling economic interdependencies were apparent in the way that service providers and co-ordinators talked about the absence of a shared identity in the wake of industrial decline. Attempts to develop new employment opportunities had

failed to generate a new image for the town. Mirroring action taken in other former manufacturing areas in the UK, the Borough Council had sought to develop the service sector in Ellesmere Port throughout the late twentieth century (Ellesmere Port and Neston Borough Council, 2009). Services and shops in Central ward were developed with a new shopping arcade built in the1980s. In 1995, Cheshire Oaks Outlet retail village was opened on the outskirts of the town, which, in 2007, was the largest retail outlet in the UK (Northwest Regional Development Agency, 2009). Data from the ONS (quoted in Cheshire West and Chester Council, 2009a) show that, in 2007, jobs in distribution and the hospitality industry accounted for 28% of all jobs held by people in the town. However, analysis of case study data indicated that the new service-sector industry had not captured the imagination of local people in the way that the manufacturing industry, with its long history in the town, had done. The following quotation from a TW provider who had worked with Ellesmere Port residents for 11 years indicates that without the prospect of work in industry, there was deemed to be nothing around which residents in Ellesmere Port could shape their lives. Discussing possible future outcomes for Ellesmere Port residents, the provider's account trails off; suggesting her sense of uncertainty towards the town's future:

> It became a very depressed kind of place … [with a] lack of future, lack of, um, I think it has a whole generation of people or more who didn't particularly succeed in school and thought that industry was the way their life would be, and with that gone... (TW provider 14).

One TW provider, who had worked in the town for two years, described the identity of residents in the town in terms of loss. In the quotation below, this provider asserts that residents in the town *do* have an identity but her definition of this identity pivots on the loss of industry:

> It's a really, really weird place isn't it? … There's nothing, sort of, about it and so people there have got an identity but what they've sort of lost, I guess, over time, in terms of sort of industry… and decline of historical sort of, big groups of people no longer work in whatever industry… (TW provider 09).

The key issue that emerged for one provider, about how residents felt about living in the town, was a lack of employment opportunity. This is likely to reflect the fact that this provider worked with unemployed people, but the comments convey a sense that residents perceived that their current state of unemployment was related to specific economic problems in the town:

> A lot of people are trying to get out of the Port because of employment [and] the current situation with Vauxhall ... They think the Port is going, employment-wise, down the pan … I know there are over 1800 redundancies in the pipeline [at Vauxhall's], and most of them are aimed at the Port area. [Residents] don't seem to think there's a lot happening in the Port now. We've had people on the [TW] programme … that have asked me for advice on what the properties are like in [the nearby town where I live] to move to [there]. (TW provider 01).

Resident accounts also indicated that the decline of local economic interdependencies shaped their experience of living in the town with residents highlighting poor employment opportunities as a particular problem for the area, which affected how happy they were living there. Referring to the lack of jobs in Ellesmere Port one resident described the town as "a rubbish hole" (TW user 05). The idea that Ellesmere Port residents were no longer connected by an economic identity was reflected in reports about the town. In a report focused on tourism in the region, the absence of a strong identity following the decline of industry was identified as a barrier to securing new business in the town:

> Despite its strategic location and interesting history, Ellesmere Port does not have a strong identity or positive image and this hinders its ability to attract new business or development. Some of this negative association comes from the industrial nature of the area, vacant and derelict sites and a perception of poor air quality. (Cheshire West and Chester Council, 2009b).

With the unravelling of economic interdependencies, interdependencies with other communities began to take on a greater significance in providers' definitions of the town. There was a perception among service providers that the town's rail and road links to other areas in the country were an asset in terms of economic opportunities, but this also seemed to create an impression of the town as an adjunct to other places without its own centre. The following quotation, from a provider who had spent two years working in the town, illustrates the way in which providers described the town's relation to nearby areas:

> I mean the chap I go out with, he lives in the Port and he hates it, he's always at mine … He just says, "Oh it just makes you feel you're just nowhere, you know." Well I can never work out why that is because, you know, you're on routes to everywhere, aren't you? (Non-TW provider 03).

The development of new interdependencies between Ellesmere Port residents and residents in nearby towns, as described below, is used to explain why residents

increasingly experienced life in the town as existing on the periphery of a developing network.

6.3.2 Lengthening chains of interdependency with neighbouring areas

With the decline of industry in the town, there was a sense among service providers and co-ordinators that residents were increasingly interdependent with others across the Northwest in terms of employment. These lengthening chains of interdependency formed a new figuration of people within which Ellesmere Port residents no longer occupied a central position. Based on data from the ONS Survey of Hours and Earnings, 2009, a recent report into economic conditions in the borough (Mickledore Ltd, 2011, p. 13) concluded that the borough itself was "not at the centre of its economic geography" given the economic opportunities in Liverpool and Manchester. Within the borough of Cheshire West and Chester, Chester formed the biggest economic centre in terms of employment (Mickledore Ltd, 2011) and there was a sense among service providers that economic interdependence with Chester had increased since the LGR. This is supported by the conclusions of a Council commissioned report into the borough's economic priorities that "the main focus of economic activity for [the council] is Chester which has 44% of total business stock and 46% of employment" (Mickledore Ltd, 2011, p. 14). Service co-ordinators identified Chester as a potential source of employment for Ellesmere Port residents. In the following quotation, one provider describes the importance of Chester in terms of opportunities for residents in the service sector but her comments reveal that residents did not necessarily share this view:

> Chester for example is a big economic driver for the service industry … but someone from Ellesmere Port wouldn't see Chester as having anything to do with them. Whereas in actual fact, it's in their borough, they are part of that borough. (Non-TW co-ordinator 01).

Research conducted by the Boundary Committee for England in 2003 (Atkinson, Holloway, Rose, & Wholey) indicated that residents in the former borough of Ellesmere Port and Neston had little emotional attachment to nearby Chester and analysis of residents' accounts in this study suggested that they had resisted increased integration with Cheshire (see section below). Providers perceived that the LGR had damaged Ellesmere Port's reputation. One TW provider described how the LGR had increased comparisons between Ellesmere Port and Chester in the local press which seemed to focus on problems in the town:

> I think the issue that the residents of Ellesmere Port have, is that they feel, because of the new council structure, they feel like they're a bit of a suburb of Chester and I think that's affecting morale. It's with things like the newspapers that concentrate all on Chester news and there's not much there of Ellesmere Port. And anything that is Ellesmere Port is quite negative: crime rates and things like that. (TW provider 02).

The lengthening chains of interdependency between Ellesmere Port residents and their neighbours were experienced by residents as a loss of control over processes that shaped their lives: an increase in the number of people shaping activity within the new borough gave Ellesmere Port residents less control over the way in which their town was perceived in the press.

Furthermore, the interdependencies between Ellesmere Port and wider Cheshire residents were described by research participants as unevenly balanced. This was reflected in the negative comparisons that were made by service providers and co-ordinators between the town and its surrounding area. Service co-ordinators working at a borough level drew comparisons between the urban and industrial development of the town and the predominantly rural nature of the rest of the borough. In 2008, the population density of the town, at 34.17 people per hectare, stood in contrast to the average for the borough as a whole at 3.49 people per hectare (Cheshire West and Chester Council, 2009a). One co-ordinator, who had worked in the town for over ten years drew a contrast between the leafy suburbs of the borough and "the nettle patch which is Ellesmere Port, which is sort of chimney stacks and heavy industry" (Service provider 05). Distinction from its rural neighbours was one of the ways Ellesmere Port's industrial identity had developed. Aspinall et al. (1982, p. iv) suggest that, because of its industrial origins, Ellesmere Port "was a town which was distinctive from the beginning: separate and different from … the surrounding Cheshire countryside" where agricultural work prevailed. Where once Ellesmere Port's unique position in the region had been supported by industry and its dominant economic position within a smaller borough, at the start of the 21st century the health and wellbeing of its residents created the contrast. The co-ordinator quoted above described how the town stood out in relation to its neighbouring areas in relation to wellbeing measures:

> Ellesmere Port is so utterly out of kilter with the rest of our Borough averages from, you know, child health to sort of, to premature mortality and all the good and bad things in between, long term worklessness, benefit dependency, domestic violence. (TW provider 08).

Administrative integration with Cheshire and the wider North West region diminished residents' sense of control over some aspects of their lives. The processes that developed from this position are described below.

6.4 Being local

One of the ways in which residents responded to an increasing sense of living on the periphery of a network, was to emphasise the importance of other interdependencies that existed between residents at a more local level. 'Being local' emerged as an important aspect of residents' experiences of living in the town and was reflected in 'privileged understanding' of the area and 'identification of outsiders'. Being local was sometimes defined in relation to the town, but often in relation to the ward or even the street in which residents lived. The ways in which local status was conveyed are described below.

6.4.1 Privileged understanding

The importance of being local to residents was revealed through the privileged understanding they conveyed of the area in which they lived. Privileged understanding involved a rejection of other people's criticisms of the area in which they lived, which were framed by local residents as coming from outsiders, and presentation of alternative views of the area. Residents who had lived in the town, or a particular area of the town, for their whole lives were proud of this fact, but their accounts acknowledged that outsiders might not understand this pride. One such resident in her late 60s defended her decision to live in the town. She said: "I've lived here all my life and I've no intentions of moving. I'm quite happy … all I've got to say is, if I didn't like it, I wouldn't be here" (Non-TW user 02). Describing the area of the town in which she lived, she rejected others' descriptions of it, suggesting that having lived in the area her whole life, she had a different appreciation of the area, "A lot of people have got a lot of things to say about, 'Oh the valley is this, that and the other, it's smelly and horrible', but I think it's gorgeous in the summer" (Non-TW user 02). Reflecting on what she defined as a static population in the town, a resident who had moved to the area in the previous 12 months described what she perceived to be an anomaly between the town's reputation and the stability of its population: "Very few people that are born here, leave for some reason …They knock the Port saying it's a bit of a dive, a bit of a dump and things but they don't tend to leave" (Non-TW user 01).

Membership within an established social network in the town was also associated with privileged understanding of the area. A resident in her 30s, who had lived in the area since birth, acknowledged what she thought other people had to say about the town before offering a different assessment based on her experiences of being part of an established social group. She said: “Ellesmere Port is a crap hole isn’t it. There is a sense of community though” (TW user 02). Similarly, connection with a family history in the area was associated with a different appreciation of the area. One resident in her 80s, whose parents had married and lived in the same street she still occupied, described how her family history had shaped her attachment to the area, apparently outweighing the criticisms that others levelled at the area. She said, “Bless us, they used to say we were the poor end, the bottom end of the Port … I love this bottom end, my roots are here” (TW user 09). Providers perceived that families often lived within the same local area and that being close to family members was an attraction to residents. Two providers described the influence of family connections on the waiting list for council properties in particular wards of the town:

Non-TW co-ordinator 03:	“For places like Stanney Grange which has a really bad reputation [the waiting list] is big …
Non-TW co-ordinator 04:	It’s family connections and people growing up there.
Non-TW co-ordinator 03:	And people want to live there to be close to their family.

Residents identified living close to family as a positive aspect of living in the town which gave them an appreciation of the area that outsiders might not share:

> [My son] lives at the bottom of the street, bottom of the, well directly opposite where I live in the square, you cross the road and his house is there … I love the bones of my son, he’s been a tremendous support … You see this is another reason why I wouldn’t move … I mean you’re just taking a chance if you move if you’ll get on with the neighbours or not. (Non-TW user 02).

Occupying a position outside of any dense local networks, residents might not have shared this privileged understanding of the area. One resident in her 60s who had no family and few friends in the town reported a different attitude towards living in the area. Having moved away from the town in her 20s and lived in different areas of Europe with a husband who “had a really good job” most of this participant’s friends were in other areas of the country (Non-TW user 03). Following a divorce, the participant had moved back to Ellesmere Port to take care of her aging mother. Interviewed after her mother’s death, the resident had a disparaging view of the

area in which she lived and some of the people she lived close to. Her account revealed satisfaction with her immediate area but also a sense of disgust towards some of the people living nearby:

> It's not a very salubrious area really … there's some … horrible people, I don't know what happened to the people in the fifteen years I went away. It's just the standard of the people, you know, their attitude; the way they speak and it's just, you know, there's a lot to be desired, you know. (Non-TW user 03).

Another way in which privileged understanding was demonstrated was through sharing memories of the town. Older residents in particular recalled how different Ellesmere Port had been during their youth and used this to present an alternative image of the town, which was connected to their decision to live in the area. One resident in his 70s, who was proud of living in the Westminster ward described how different the area had been over 60 years ago: "When I came in the 50s, this was like a Wild West town … It was so riotous and boisterous, it was really lively, you know, all the pubs ... full of people" (Non-TW user 04). Within this particular part of the town some older residents thought of Westminster as the town centre, which it had been before the expansion of the town in the 1970s. Describing the relocation of services to Central and Whitby wards, one resident in her 80s, who said that she would never leave the Westminster ward, described the changes in Westminster with sadness:

> It was a hive of industry, this bottom end was and it *was* Ellesmere Port but, as I say, it's gone now and the [shops] are up Whitby … [Westminster ward] was Ellesmere Port then, that was the Port, there was not much up above the station … The bottom end [was] very busy with works … the canal where the barges used to be … [the] flour mill was going and I was very happy and I got married and I was very happy then. (TW user 09).

These accounts were used by participants to present an alternative view of the town or the immediate area in which they lived that was based on family connections and an appreciation of history.

6.4.2 Identification of outsiders

The importance of *being local* for residents was also reflected in the *identification of outsiders* among some resident groups. Being local was defined in relation to the areas that residents would not frequent or the residents that they would not associate with. There was a perception among providers that some residents across

different areas of the town would not mix with one another and that this was reflected in problems between youth gangs. One TW provider who had not worked in the town prior to TW described the situation as it appeared to him after spending 12 months working in the town:

> But there are different territorial things within the Port; [residents] that say "We're not going to mix with this group, we're not going to mix with that group". So I think there's a lot of … gang problems there … People from PK [the Parklands estate within the town] don't mix with other estates because they have got a lot of 'well-known families', as I think they would say. (TW provider 01).

Differentiation between residents sometimes manifested in hostility towards outsiders. A TW provider who was not from the area had been warned to expect trouble from local people if he went into a pub within the Westminster ward:

> Local people who work around here and staff in the different training organisations or the job centre said, "Oh, don't go in The Knot for a drink, it's full of scallies, if they know you're not from the Port you might be in trouble." (TW provider 01).

This was reflected in residents' accounts. One resident who had moved to the town during the last 12 months described how it felt to enter a particular pub in the town for the first time. Her account suggests that dense networks of relations between residents could make it difficult for newcomers to spend time in the area:

> It's a friendly enough pub but it's very intimidating when you first walk in … it's like, [grimaces] eeeh! They're very, very loyal people to the people that they like, but that can work against you … If they don't like you, you're not going to be made very welcome in the town because everyone sort of knows everybody. The Jockey, the Station, the Knot are where all the bikers hang out and the bikers' girlfriends and bikers' kids so, I mean, you've only got to mention one person's name; "That's my uncle, he's my dad's best mate". Everyone knows everybody because a lot of people were born and bred here. (Non-TW user 01).

Subsequent discussion with this participant revealed that the regular customers within the pub had intervened when the participant's former partner had come to the pub and threatened her with violence. The participant said that she had felt protected by the behaviour of the regulars and was glad that she had earned their loyalty, she said that she was "relieved that there was people there keeping an eye out for me if needs be. And that's very much what Ellesmere Port's about" (Non-TW user 01).

Differences between residents in different parts of the town were also reflected in their use of services. Providers described how some residents would not leave the area in which they lived to use services elsewhere. The provider quoted below attributed this behaviour to the distinct identities of the wards:

> We know that people are very territorial … People in Westminster don't want to go out of Westminster, don't want to go over the bridge. People in Stanney don't want to go across the skate park at Whitby Park despite it being, you know, half a mile away. It's one of those places where … each area sees itself as quite distinct from others. (TW provider 09).

Socio-economic differences and the geography of the town formed part of the distinctions between the wards. There was a perception that residents in Westminster in particular were reluctant to spend time in other areas of the town. One provider who had not worked in the area before TW described the differences between Westminster and the rest of the town in terms of class differences. Her reference to the geographical position of the town also highlights the tendency to separate the ward from the rest of the town in accounts about Ellesmere Port:

> There seems to be a massive divide from the Westminster area, they seem to be their own distinct community to the community living at the other end. I mean, the houses are a different kind of housing stock really. You've terraced houses in Westminster and you've got semi-detached and you know, you have got some terraces… so there is a kind of, I don't want to say class divide, there's certainly a divide between Westminster and the rest of Ellesmere Port. (TW provider 03).

Differentiation between residents in the wards on the outskirts of the town and the rest of the town were also apparent. One service co-ordinator who was resident in the town described residents in the ward that neighboured her own as "posh" and suggested in jest that she would only visit that area for a "holiday" (Non-TW-co-ordinator 04). Informal conversations with residents from Little Sutton, a more affluent part of the town, revealed that these residents were less likely to associate themselves with the town. The quotation below, from a provider who had worked in the area for 8 years, reflects a common statement about the importance of local ward boundaries to resident identity:

> I think people probably feel stronger to the ward that they live in rather than Ellesmere Port as a whole and feel quite passionate about that, particularly if they are involved in groups or schools … when you ask people where they live or their address it is very much the ward that they live in … they might say, "Little Sutton, Cheshire," not: "Little Sutton, Ellesmere Port, Cheshire." (TW provider 12).

The consequences of these processes for relations between providers and residents in the town are discussed below.

6.5 Influence over services

One of the consequences of living on the periphery of a regional network was that residents felt unable to influence the provision of services within their area. This was reflected in the sense of neglect they experienced from service providers and the depiction of physical barriers between them and a number of services and activities in the town.

6.5.1 Sense of neglect

There was a perception among co-ordinators that the town had been "forgotten" by service providers and funders (TW co-ordinator 01). Co-ordinators were optimistic about a number of developments that were emerging during this period, in terms of a planned economic regeneration scheme focussed on housing and business development along the Ellesmere Port waterfront and a number of service reorganisations, including the LGR and TW. However, at this particular juncture, there was a sense that these financial and social investments in the region were "long overdue" (Non-TW co-ordinator 02). One TW co-ordinator described the sense of neglect she had witnessed working in the borough over the preceding 5 years:

> Historically … it just seems to be an area of deprivation that is never really mentioned … there was no particular money spent on that area. (TW co-ordinator 01).

The sense of living on the periphery of a network and the strength of local identities influenced the way in which residents related to service providers. The decline of shopping and leisure facilities in the Westminster ward and the development of new facilities elsewhere was understood by its residents as a reflection of their powerlessness in relation to service providers. In the 1950s, a new shopping complex had been developed in what later became the Central ward. A local survey of shopping habits conducted by Sherlock in 1969 (cited in Aspinall, et al., 1982) indicated that this had become the major site for Ellesmere Port shoppers by this time. Unravelling economic interdependencies within Westminster, which had accompanied the closure of the large employers in the area, was associated by residents with the decline of shopping and leisure facilities. Describing this decline in Westminster, one resident in her 80s said: "The bottom end has gone; all the bottom end. It's absolutely gone. There's nothing. There was lovely parks; there's

nothing now, it's all gone … it is pretty dead down here" (TW user 09). Another resident in his 70s described the decline of the services in the ward as a process of relocation, with other areas being regenerated at the expense of the Westminster ward:

> Now in those days the Westminster had all the banks … the Co-Op dairy, we had a Co-Op butchery, you know we had everything down here …eventually, everything opened up down the other end. Cheshire Oaks … [shopping] outlets got built, the [shopping] arcades got built and gradually the banks closed, they moved further up town and then the Co-Op closed … [The developments were] a disaster for the Westminster. (Non-TW user 04).

Service co-ordinators and residents described experiences of neglect in other wards. Two service co-ordinators, both of whom lived in the town, described relations between service providers and residents on the Stanney estate within Stanlow and Wolverham ward as hostile. Describing the reaction of local residents when a bail hostel had been developed on the estate, these co-ordinators perceived that the entrenched views of residents towards service providers had shaped their response:

> Non-TW co-ordinator 04: "People [on the estate] just think, "Oh, it's Stanney, they don't care".
>
> Non-TW co-ordinator 03: And the residents say that themselves, you know, "Just dump any shit you like on Stanney because it won't matter" … and that's how they see it.

The introduction of initiatives in this particular area in the past, such as a recycling scheme, had been met with hostility from residents according to one of the co-ordinators. Her comments highlight the suspicion she saw among residents towards the motives of service providers:

> Because of indices [of deprivation], things tend to get piloted in places like this. So people believe that they try it out in Stanney because if it doesn't work, it doesn't matter, you know, that kind of thing. They don't see it as being privileged for having a pilot, they see it as being [like guinea pigs]. (Non-TW co-ordinator 04).

Local government integration with Cheshire had also been experienced by residents as a reflection of their decreasing sense of influence over local service provision. One resident suggested that LGR had made Ellesmere Port residents suspicious about fair allocation of funds across the region:

> Because we're part of Cheshire West and Chester [authority], which is another reason now we're feeling more deprived … people are now making the comparison with what's going on in Chester … We've all got the same budget, supposedly … But it looks like

> Chester is getting a bigger share … People from Ellesmere Port, it's … like [they've] given up; [they say]: "We're in with Chester now, we'll get nothing," you know. (Non-TW user 04).

This illustrates the ways in which social processes involving large numbers of people across wide geographical areas, such as the decline of industry across the UK and LGR, influenced resident relations with service providers at a very local level. A history of declining influence over their local area shaped resident expectations of service providers and the discourse of neglect that emerged from long-term processes of change perpetuated a sense of suspicion which shaped relations at the local level.

6.5.1 Depiction of physical barriers

Physical landmarks in the town were interpreted as barriers between residents and a number of resources in the town. Such 'barriers' fed into a discourse of separation between residents and providers. Situated on the western boundary of the town at the edge of the estuary, the Westminster ward was separated from the rest of the town by the railway line. Access to the rest of the town was gained via a bridge over the railway into Central ward. Service co-ordinators identified the bridge as a "psychological barrier" to entering the town for Westminster residents (Non-TW co-ordinator 04). Access routes in and out of the area had been restricted in the 1970s with the extension of the Merseyside motorway (the M53), approved according to Aspinall et al. (1982) in order to ease congestion on local roads caused by commuters and the transportation of materials to the new Vauxhall plant. The motorway development was described by older Westminster residents as a life changing event which "upset a lot of people" (TW user 09). One resident described the lasting impact that the development had on the area:

> The biggest disaster that happened to the Westminster … in … about 1974 … The motorway carved the Westminster in half … [it] completely cut off the town. There's only one way you can get there now and that's down Grace Road and round the roundabout … That's the only outlet that the people of Westminster have got. (Non-TW user 04).

Access to the town centre for Westminster residents was further restricted by low car ownership and what residents and providers described as "pretty poor" bus service (Non-TW co-ordinator 03). Providers perceived that this affected residents' ability to access services in the centre of the town. One TW provider said, "There's no public transport up there, the bus doesn't go that far and that is a huge barrier [to

using services] to a lot of people" (TW provider 03). In this respect, the practical difficulties that were experienced by residents perpetuated a sense of isolation in relation to using services.

The large-scale economic developments in the town had generated feelings of exclusion among groups of residents in other areas of the town. The development of the Cheshire Oaks retail outlet, positioned immediately behind the Stanney estate, was a source of contention to residents on the estate according to co-ordinators. Co-ordinators recalled that the development had gone ahead without consultation with residents despite the fact that the shops were built within metres of their homes. One co-ordinator perceived that the erection of a fence between the estate and the private shopping complex signalled to residents that they were excluded from the opportunities that the complex might provide in terms of employment:

> The [Stanney] community doesn't see [that] it's got any relationship [to the complex] … no one from that estate would even think that they can get a job there but everyone comes in from Chester and gets jobs there. So you've got an estate with high levels of unemployment next to one of the most successful European retail parks, that's weird isn't it [sarcastic tone]? But for some reason we decided to put a big wooden fence up the centre of that community, "No, you're not part of that". (Non-TW co-ordinator 01).

These instances reveal how large-scale economic change influenced the development of social divisions across physical boundaries that shaped the way in which residents related to services in their area.

6.6 Conclusions

This chapter sought to understand interpretations of what it meant to live in Ellesmere Port. By conceptualising the town as a figuration of interdependent people, whose actions were influenced by their connections to a range of other people, it has been possible to uncover the processes through which ideas about the town have been formed. Examination of the history of the present-day figurations shows how resident relations to one another and to service providers have changed over time. The findings indicate that long-term social processes that extended beyond the geography of the town shaped experiences of social isolation among residents. The decline of economic interdependencies and increasing interdependencies with others across the region shifted the balance of power between Ellesmere Port residents and their neighbours. The sense of powerlessness that residents experienced in relation to people in the wider borough

shaped a perception that local identities, based on small and dense social relations, had value because they facilitated a sense of belonging which justified their residence in an area that had lost other sources of prestige. Conversely, investment in relations with service providers (and hence people beyond their immediate locality) had historically led to disappointment among residents, which influenced their low expectations of service providers. This interpretation indicates that relations between providers and residents in the town during the period in which TW was implemented need to be understood with reference to the expectations of both groups. It is to these expectations of TW that attention is now turned.

Chapter 7

The Commissioning Process:

Early Provider Relations

7.1 Introduction

This chapter examines the social processes through which people came to be involved in the delivery and co-ordination of TW projects. Service co-ordinator and provider expectations regarding the consequences of the initiative are also examined. The commissioning process and related expectations established the conditions under which TW activities were delivered and their examination here establishes the basis for further analysis of relations as they developed over time in subsequent chapters. The findings presented here have been generated through documentary analysis, qualitative interviews and non-participant observation. The commissioning process is examined first, before the influence of different groups over the strategy for TW and the expectations of service co-ordinators and providers are considered.

7.2 The development of a provider network

This section of the chapter describes and accounts for the ways in which the network of TW service providers and co-ordinators was developed. A brief overview of the processes through which people came together is provided before the analytic categories that formed the framework for understanding this part of the TW process are introduced.

An application to the BIG Lottery's Well-being Fund was made in mid-2006 for a North West portfolio of projects (collectively called TW) that would cover, among other geographical areas, Ellesmere Port. There were three stages to the process through which the network was developed. The first stage related to the formation of a regional team of service co-ordinators who would oversee the development of a regional bid. Following a BIG Lottery funding launch event, a multi-sector consortium, including representatives from the Department of Health, regional public health networks, Voluntary Sector North West and the Northwest Development Agency, was formed to co-ordinate a bid for a North West programme of activities.

This group called itself the Northwest Wellbeing Partnership. The second stage in the development of the network related to the formation of area programmes, which were managed by a programme lead. Service co-ordinators in each of the 10 TW areas were approached by the members of the Northwest Wellbeing Partnership to lead the bid for their area's programme. Within Ellesmere Port, service co-ordinators in the PCT were approached, who developed a programme bid in conjunction with members of the Ellesmere Port and Neston Local Strategic Partnership (LSP). The third stage in the network development was the selection of service provider organisations to deliver projects within each programme. In Ellesmere Port, providers were invited to submit project proposals and an appraisal panel from within the LSP was formed to select up to ten projects to form the local TW programme. The panel was made up of three members of staff from the PCT's public health department, a policy officer from Ellesmere Port and Neston Borough Council, and a Chief Officer from a voluntary association based outside of the town.

7.2.1 It's who you know

The concept 'it's who you know' reflects the ways in which the commissioning process was influenced by relations between service providers and co-ordinators that had developed prior to the introduction of the Lottery's Well-being Fund. The category captures the way in which co-ordinators of the initiative in Ellesmere Port, by virtue of their position at the centre of a network of providers and co-ordinators, had more influence over the commissioning process than providers. The Northwest Wellbeing Partnership, for example, was formed from a network of service co-ordinators already known to one another. These people had developed relationships through a health conference organised by Groundwork Northwest several months prior to the launch of BIG's Wellbeing Fund. One TW co-ordinator explained that the Partnership "was bought together from some of those players who'd been involved in that … conference" and that the "group [had] sort of evolved" over time (TW co-ordinator 05).

At the programme level of network formation, established relations between providers and co-ordinators within Ellesmere Port influenced whether or not providers were invited to bid for TW funding. The process of recruiting organisations to deliver projects differed between programmes but within all areas there was an element of competition between organisations for funding. Some programme leads encouraged local project applications via publicity events and press releases; within

Ellesmere Port, 17 public and voluntary sector organisations were invited to submit proposals for projects through personal invitation from the TW co-ordinators. The invitations reflected the networks of these co-ordinators. One TW co-ordinator said that the process of inviting providers "was a bit of, who did we know and who would be interested"; she described how she had approached providers who "had come to [her] previously [to express] an interest in working in Ellesmere Port [whom she] knew … wanted to develop and expand [their work] within the area" (TW co-ordinator 05). One provider, who was eventually unsuccessful in obtaining TW funds, explained that the idea for her project "came from the TW co-ordinators; they said that they wanted us to put in [a bid]" (Non- TW co-ordinator 02). Another TW provider explained how her connection with a TW co-ordinator led to the invitation to bid, explaining that the co-ordinator "just asked if we were interested because [she] used to [work with us] a few years ago" (TW provider 05).

TW co-ordinators sought bids from providers with whom they had established relationships partly because they did not trust the work of providers whom they did not know. Programme leads were encouraged by members of the Northwest Wellbeing Partnership to seek bids from VCS organisations (Northwest Wellbeing Partnership, personal communication, 2006) but TW co-ordinators perceived that the VCS in Ellesmere Port was "not that well developed" and that it was "hard work to … get good quality bids in" (TW co-ordinator 04). TW was viewed by co-ordinators as an opportunity to "kick start" the VCS within the town (TW co-ordinator 03) and to improve the quality of VCS services provided to local people. TW co-ordinators' perceptions of existing VCS provision in the town persuaded them that the best bids would be secured through direct contact with organisations that were already known to them and influenced TW co-ordinators to look beyond Ellesmere Port for possible TW providers. These examples illustrate how a small number of people, by virtue of their central position within a figuration of service co-ordinators and providers, influenced which people were approached to bid for TW funds.

7.2.2 The restricted influence of outsiders on the network

The process of network formation influenced power dynamics between providers in the town. Some providers and co-ordinators were pushed to the periphery of the TW network during the bidding phase. This was revealed by the way that groups of co-ordinators communicated with one another during this period. The consortium's application to BIG stated that a multi-sector approach to the writing of the bid had

been adopted "in order to avoid unnecessary competition and duplication of effort" among providers in the region (Northwest Wellbeing Partnership, personal communication, February 21, 2007, p.5). However, documentary analysis showed that a bid was also submitted by another team of service co-ordinators working independently within the region. TW co-ordinators reported that that there had been little communication between the people involved in the two bids: several months after securing funding for TW, the TW co-ordinators said that they knew very little what was being delivered within the other funded programme in the region. Describing the bid writing process, one co-ordinator said that there had been a sense of suspicion between groups of providers involved in bidding:

> There was an amazingly small amount of talking and communicating between the groups of organisations that were putting the bids together as well, quite a lot of paranoia … thinking that the other group was going to get all the money for the region and that we weren't going to get any. (TW co-ordinator 02).

The process of inviting bids through personal invitations constrained some providers from bidding. In the Ellesmere Port programme, one TW co-ordinator described how "[the co-ordinators] did miss somebody" when inviting organisations to bid. She perceived that providers at this organisation felt that "they were being left out of the loop" (TW co-ordinator 04). Another co-ordinator explained that some providers had not been invited to submit a project proposal in Ellesmere Port because there was an expectation that they did not have "the skills to maybe manage a project the way we [as co-ordinators] would want it managing" (TW co-ordinator 03). She explained that "some of the smaller agencies were effectively 'frozen out'" of the bidding process.

Other providers experienced a sense of isolation when their proposals for funding were rejected. As one TW co-ordinator explained, there were providers "that put quite a lot of development work in [who were] squeezed out of the equation" (TW co-ordinator 02). In Ellesmere Port 19 project proposals were received by TW co-ordinators from 17 different organisations. The appraisal panel members selected eight projects to fund in Ellesmere Port, delivered by six different organisations. Some providers who were unsuccessful in obtaining funding for their project idea felt a sense of bitterness about this. One non-TW co-ordinator whose proposed project had been "cut from the final" funding allocations said that she felt "bitter" at having been rejected for funding (Non-TW co-ordinator 02).

7.2.3 Fixing the fit

'Fixing the fit' reflects the way in which a group of providers were linked together in TW programmes on the basis of co-ordinators' expectations regarding co-ordinated working rather than on the basis of relations between providers. The selection of TW providers was based, according to the written bid to the Lottery, on the level of co-ordination between providers within a geographical area but analysis of interview data suggested that this did not reflect the selection decisions made. One of the criteria used to assess project proposals examined the extent to which potential TW providers could "demonstrate a local and regional strategic fit" with other providers (Northwest Wellbeing Partnership, personal communication, 2006). "Strategic fit" was interpreted by TW co-ordinators as the way in which providers "work[ed] … together" (TW co-ordinator 02). Minutes from the appraisal panel meeting showed that networks between providers were of importance to the appraisal panel in its selection decisions. One project proposal was rejected, for example (according to the minutes), on the grounds that "the appraisal panel were concerned that links with local initiatives had not been made" by the providers (minutes from the appraisal meeting February 2007). Analysis of observation and interview data however, suggested that the strategic fit of the projects had been difficult to interpret at the proposal stage. This was reflected in the comments of one TW co-ordinator after providers had been commissioned:

> We didn't have a broad enough understanding of what employment initiatives were already within Ellesmere Port prior to us then introducing new ones … When I reflect back now, you know if you could do things differently, [I would try to get an] understanding … about what else [was] happening [in the town] already. (TW co-ordinator 04).

One TW co-ordinator suggested that the potential for strategic co-ordination between different projects within one TW programme (not Ellesmere Port) was worked out after the projects had been selected for inclusion and that the relationships between the providers had been exaggerated in the bid to the Lottery:

> So three food projects were picked in [that area], and [the providers] were taken into a room … and spent an afternoon working out how [they] fitted strategically and as I said before, [they] didn't really fit strategically at all, it was all a bit of a [pause], bit of a fix really for lack of a better word (TW co-ordinator 02).

The expectations that TW co-ordinators had regarding co-ordinated working are discussed in more detail towards the end of this chapter.

7.3 Capacity to influence TW strategy

The extent to which TW providers and co-ordinators influenced the strategy for TW activities reflected the dynamic network of relations between funders and a broad range of service co-ordinators and providers. Power dynamics between these people shaped the way in the strategy developed and the entanglement of co-ordinators and providers in various other networks of relations constrained the extent to which they could influence TW strategy.

7.3.1 Jumping through hoops

'Jumping through hoops' reflects the way in which providers and co-ordinators worked to maintain existing power balances from which they benefitted. This was reflected in the way that TW co-ordinators had designed a strategy for TW according to what they perceived the funders wanted. There was a perception among TW co-ordinators that BIG "pretty much prescribed" the use of the VCS in its funding activities (TW co-ordinator 02). TW co-ordinators instructed programme leads that local programmes should reflect BIG's strategic vision:

> In line with the BIG Lottery's strategic vision we would expect the Voluntary & Community Sector to play a significant role in all aspects of your programme, and would like to see their role clearly outlined within your proposal. (Northwest Wellbeing Partnership, personal communication, February 21, 2007, p.7)

This advice was adhered to by the programme leads. Co-ordinators in the Ellesmere Port programme said that they had primarily targeted the VCS for project proposals to fit with the requirements of the funders:

> We had to look to the third sector to deliver as much as possible … Because that had been stipulated in the bid. You know, the PCT couldn't say, "We'll run ten projects," because that wasn't in the ethos of the bid. (TW co-ordinator 04).

There was a balance for co-ordinators to strike between what they thought was needed and what they anticipated funders would prioritise. The quotation below illustrates the balancing act that co-ordinators performed to try and increase the likelihood that they would get funding:

> In one breath you've got to obviously fit with what BIG are looking for but equally, if not more important than that, was to make sure that the proposal actually was addressing the right needs in the right place, making best use of that resource so, you know, sort of a balance there. (TW co-ordinator 05).

There was a perception among providers that they knew what was needed in their local areas but that it was necessary to comply with the funders' requirements in order to keep getting funded. Once funding had been approved, TW providers were careful to ensure that they delivered according to what had been agreed in the bid as they were "unsure as to how much [they] [could] change [their] plans from the original bid" (TW provider 10). When providers did want to make changes to their projects, they made sure that they had approval from the funders and that they were able to "prove why [a certain way of working] had not worked" (TW provider 12). One provider, quoted below, described the process of getting approval for changes as "slightly bureaucratic" but necessary in order to please the funders and keep hold of funding:

> It's the BIG Lottery outcomes [that we're working towards] which has meant that we've got walking [as an activity], because you've got 'cycling and walking' as an outcome. So therefore we immediately get walking and you think, 'Well, why?' [Eventually we decided] if we jump through the right hoops … we'll just concentrate on [something else]. (TW provider 02).

7.3.2 Limited influence of providers in bid writing processes

The extent to which TW providers and co-ordinators were able to influence the strategy for TW activities reflected the fact that some people had not been involved in the bid writing process. A small group of people within the TW network (the Northwest Wellbeing Partnership) developed the management structure for the initiative and TW providers had not been involved in this process. In the development of the structure, some providers and co-ordinators perceived that power balances between providers and co-ordinators had been maintained. For example, leaders within the structure had been selected based on their past experience in leadership positions. The bid consortium appointed Groundwork North West to the role of portfolio lead, which entailed performing the role of accountable body for Lottery funds; monitoring project and programme delivery and ensuring compliance with BIG's funding criteria (Northwest Wellbeing Partnership, personal communication, February 21, 2007). According to TW co-ordinators, it was agreed among the members of the bid consortium that Groundwork North West should lead the bid as "the only organisation in that partnership that could actually demonstrate a track record delivering programmes and managing public resources" (TW Co-ordinator 05). Similarly, the PCT was appointed as the programme lead in Ellesmere Port "because of past experience because … [as an organisation it] had quite a bit of experience with funding streams" (TW co-ordinator 03). Within the

funding application, TW co-ordinators stated that the Programme Leads would administer TW funding claims and monitoring reports from the providers within their programme before they were sent to the portfolio co-ordinators. These responsibilities were shared out between a number of co-ordinators at the PCT.

The people who had been excluded from this process expressed dissatisfaction with some of the decisions that had been made. TW providers were uncertain as to why the PCT was involved as an arbitrator for the Ellesmere Port TW funds. The following quotation from a provider within the VCS captures some of the uncertainty and resentment that was expressed by TW providers about the PCT's role within TW:

> In terms of the PCT, I don't quite understand the relationship and where it fits in because, I don't understand – obviously they've got their health and wellbeing targets and they dish out the money but I don't understand why Groundwork couldn't dish out the money. (TW provider 02).

Concern was expressed by co-ordinators and providers who had not been involved in the bid consortium about the role of the VCS in some of the central decision making processes. The comments below from a TW co-ordinator help to explain how the exclusion of some groups from decisions about the management structure for the initiative perpetuated the sense of disempowerment among some providers in the VCS:

> When I first … began learning about Target Wellbeing and how it was structured, with the statutory partners running each of the programme areas, I found that a little bit kind of disturbing …'Cos it kind of suggests that the third sector organisations don't have the capacity to manage themselves and they need the statutory sector to do it for them. It's kind of like a bit of a big brother sort of thing going on there. (TW co-ordinator 02).

The division of labour within some organisations and a high turnover of staff in others meant that people delivering TW projects had rarely been involved in the development of their organisation's TW bid. A TW provider within a local branch of a national VCS organisation perceived that the bid writing processes within her organisation sometimes resulted in standardised project proposals which did not necessarily reflect the reality as understood by providers responsible for delivery:

> If you have a system whereby people at a certain level are writing tenders, they don't necessarily tend to be the people who are actually … delivering activities on the ground with communities. So there's a .. standard [organisational] approach of, "This is how we work with local communities," and there does need to be a bit of sort of internal tweaking as to how … that fits with real-life neighbourhoods. (TW provider 09).

This influenced a sense of disempowerment among TW providers towards the strategy for their project. Discussing the focus on particular geographical areas in their project, two TW providers said, "We personally didn't choose [the areas]; they were there in the bid" (TW provider 08). Her colleague agreed that the areas "were chosen for us and then we have to start the [activities] from those places" (TW provider 07). TW providers did not always completely approve of the way that they had been asked to run activities by others in their organisation. This often meant that the providers delivering the activities felt some resentment that the activities they were delivering did not reflect what they would prioritise:

> I have no idea how [the bid] was put together and how people assessed the need and what should happen but it seems a lot about number crunching [was done] so, you know, there wasn't anybody sort of coming to [our organisation] that I know of, and saying, "Okay given your client group, given the needs of this area, what do you think would work?" (TW provider 14).

Another consequence of providers delivering a project proposal written by someone else was that they did not always have a clear vision of their project strategy. This could be exacerbated by the high turnover of staff in some organisations. In these instances, there were sometimes delays in the development of TW activities as the following quotation reveals:

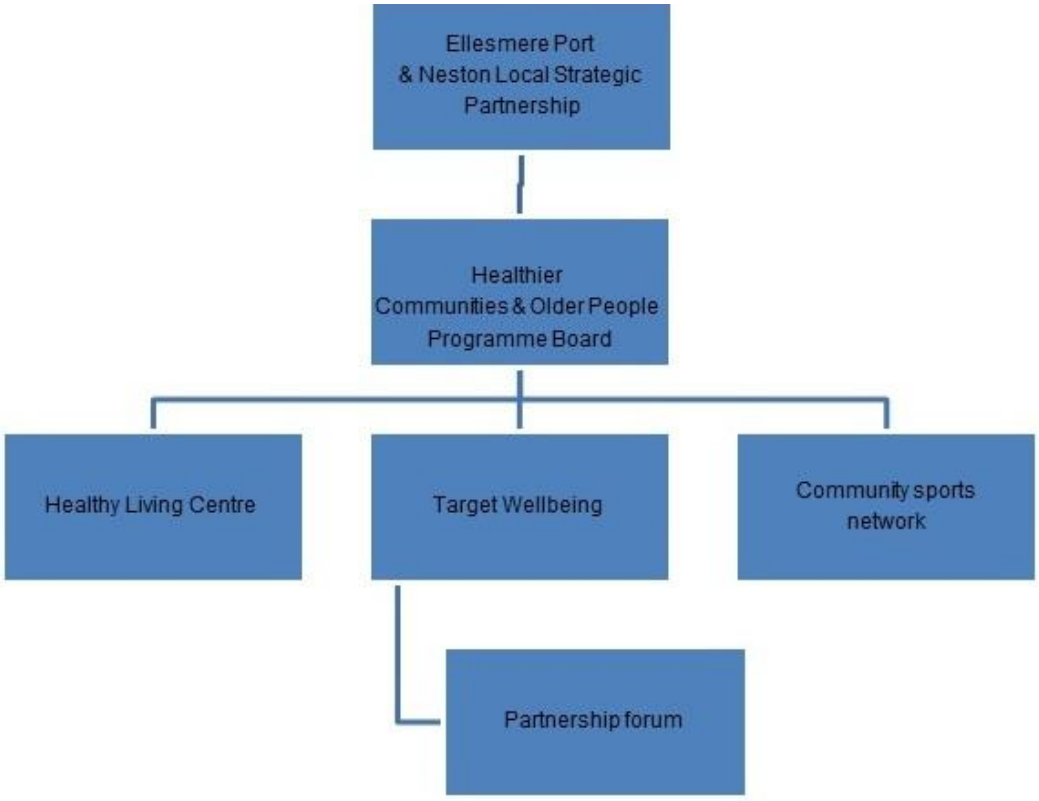
> It's taken me a while to really work out how I want to go forward because you inherit a 6 month plan say, for a project, and you can't really understand what the reasoning was behind that unless you were the one thinking [about the plans] or had discussions with [the people writing] them. (TW provider 02).

7.3.3 Slipping through the net

'Slipping through the net' reflects the way in which co-ordinator actions were mediated by those of other people in their network, including other service co-ordinators and policy makers, making it difficult for co-ordinators to influence the way in which TW activities were integrated into local service provision plans. Changes to the organisation of PCT and local authority structures impacted on the capacity of providers to concentrate their actions on the promotion of TW. Slipping

through the net reflects the way in which TW activities slipped from the agenda of co-ordinators partly because TW providers were engaged in work activities beyond their TW responsibilities. There was a perception among TW co-ordinators that the PCT had become the lead organisation for the initiative within the area by "default" because of its links to health (TW Co-ordinator 04) and because no other co-ordinator had stepped forward to lead it. Service co-ordinators within the PCT understood TW as part of a larger strategy of wellbeing activity in the area, as illustrated by Figure 7.1, a diagram they produced and disseminated locally.

Figure 7.1 Local governance structure of TW in Ellesmere Port (reproduced from a presentation delivered by TW co-ordinators)



There was also a sense among co-ordinators that the LGR, 12 months after TW funding had been won, and changes to the structure of the PCT, which were coming to fruition at the same time, had diverted co-ordinators' attention from TW activities. The following quotation from a non-TW co-ordinator reveals that the initiative did not get the attention from co-ordinators that some people thought it should have done:

> Because of the massive upheaval of local government reorganisation we as a public sector, as a health, as a Local Authority didn't ask some of the key questions, [about] Target Wellbeing. (Non-TW co-ordinator 05).

One TW co-ordinator explained that the initiative had not been fully embedded in her work because she had been uncertain about whether or not it was the responsibility of the provider or the commissioning team in the PCT. She explained how this uncertainty had influenced her and her colleagues to avoid detailed involvement with TW activities:

> Things like, "Oh you've got to do something about Target Wellbeing" crop up … but … it's not a line in my work plan although I could make it a line if I wanted to, I could justify it … but I don't know, it's been a bit of a mystery, I think, to all of us in the team. (TW co-ordinator 03).

The extent to which providers' sense of influence over TW plans shaped relations during delivery is discussed in the following two chapters.

7.4 Divergent expectations and emotional responses

The expectations of TW co-ordinators and providers shaped the way in which they worked with one another once funding had been secured for TW. This section of the chapter considers how these expectations were formed. Expectations differed among providers and co-ordinators, reflecting their different positions within a service provision network and an emotional investment in meeting targets that were set.

7.4.1 Targets: speaking the language of funders

Demonstrating the consequences of TW activities for residents was important to TW providers and co-ordinators but differences emerged between these two groups in terms of the 'outcomes' that might develop and how they might be recorded. An interest in quantifying the changes that might develop for residents was demonstrated by TW co-ordinators. This reflected their emotional investment in demonstrating the scale of change initiated by their work and an ingrained way of working towards measurable outcomes. Reporting on TW activities was a requirement for BIG Lottery funding although the funders did not stipulate what should be reported. Through discussion between TW providers and co-ordinators, and the BIG Lottery, targets were set for the number of local residents engaged in

activities at individual projects across the northwest TW portfolio. Defining 'engagement' with the project proved to be problematic, as discussed below, but the targets were closely related to the success of each project by TW co-ordinators. Describing how she would assess the success of TW, one TW co-ordinator said: "We predominantly will use [the target monitoring tools] for those projects, particularly around [resident] numbers" (TW co-ordinator 01).

Changes in health indicators at an individual level were also important to co-ordinators. The consequences that TW co-ordinators anticipated from resident involvement in TW were expressed as outcomes, measured through evaluation methods. Outcomes for the initiative were devised by TW co-ordinators in liaison with a commissioned research team at the PHO. These outcomes were established before the projects were chosen and therefore reflected the expectations of co-ordinators rather than providers. Based on the three themes identified by the Lottery (physical activity, healthy eating and mental wellbeing), 11 sub-outcomes were devised by TW co-ordinators and researchers at the PHO. The sub-outcomes are shown in Table 7.1.

According to TW co-ordinators and PHO researchers, these outcomes were to be measured against baseline measurements at each project across a sample of residents who had been involved in TW activities. The results of this evaluation were to be used in conjunction with the resident participation data to estimate the number of people who had benefited from the project (referred to as 'project beneficiaries'). The ability of providers to demonstrate health outcomes was important to co-ordinators, forming one of the criteria used to assess and commission TW providers. This is shown in the reference to "added value" to usual service provision within the project selection criteria cited above and is illustrated succinctly in the quotation below from a TW co-ordinator:

> When… they looked at the proposals that had come in … ultimately they had to be confident that there was the ability to deliver health outcomes (TW co-ordinator 05).

Table 7. 1 Outcomes defined and measured across Target Wellbeing projects

BIG Lottery Theme	Sub-outcomes
Mental wellbeing	People benefitting from improved self-management
	Increased sense of belonging within their community
	People benefitting from improved job control
	Increased self-esteem
Physical activity	Increased cycling & walking
	More active in their daily lifestyles
	Increased use of open space for physical activity
Healthy eating	Increased availability of healthy food
	Improved levels of food preparation and cooking skills – preparing food from scratch
	Increased knowledge about healthy eating-shopping
	Increased number of people involved in food growing

Co-ordinator accounts revealed that TW co-ordinators had come to rely on "outcome" data when commissioning and developing services and that this was an ingrained way of working. Discussing how she would judge the value of TW projects one TW co-ordinator said "let me look at … reported outcomes, patient reported outcomes, for me work every time" (TW co-ordinator 03). In the following quotation, a TW co-ordinator describes the links between TW outcomes and wider LSP targets for the area, indicative of the role that targets played in the everyday work of these co-ordinators:

> [We want to be] hitting the local targets for getting people, more people into exercise, healthy eating and reducing disease, coronary heart disease and all that … and if [TW] hits those then we are more likely to get more funding for future work. (TW co-ordinator 01).

There was a tension within TW co-ordinator accounts regarding their understanding of the "determinants of health" (TW co-ordinator 04) in Ellesmere Port and the consequences they anticipated from TW activities. Within the previous chapter, for

example, it was shown that the causes of health problems in Ellesmere Port were related by co-ordinators to processes of long-term change. TW and non-TW Co-ordinators expressed a view that changing circumstances in the region would take years, as the following quotation shows:

> It's took 50 years for [the town] to come down so [regeneration] is not going to happen overnight; you're talking about generational change, that's how long it will take because it's hard to change people's views and perceptions like that and just because you want it to, you know, it's not going to happen. (Non-TW co-ordinator 02).

Despite this, TW co-ordinators expressed expectations that health changes, in terms of coronary heart disease prevalence for example, could be demonstrated during the 4 year lifespan of TW. This can be explained in terms of the long-established dependency of TW co-ordinators on a range of funders from whom funding was received according to results. The following quotation from one TW co-ordinator shows how the influence of central government on funding for health projects shaped her expectations of the TW evaluation:

> [We wanted evaluation] tools that would give us health outcomes data that would be comparable with the regional lifestyle survey so that we could actually compare areas that had Target Wellbeing investment with other areas that hadn't had that investment … [to get evidence] that would be acceptable to the Department of Health in future commissioning. (TW co-ordinator 05).

There was also an indication that this was the way in which TW co-ordinators were expected to work by their funders. In the following quotation, a TW co-ordinator highlights the pressure that TW co-ordinators experienced to meet the targets set by funders:

> Nobody's going to be breathing down [the BIG Lottery's] neck that they haven't achieved their health outcomes whereas for the PCT that will be the case and somebody will be … saying, "But you know, you've not delivered your, whatever it is, target that you had". (TW co-ordinator 05).

The ways in which these views contrasted to those of TW providers is discussed below.

7.4.2 Hostility towards targets

TW providers had a different view on measures of success, which reflected differences in their position in relation to residents, funders and the TW commissioning process. Providers thought that TW co-ordinator expectations,

reflected in the individual project targets, were not "realistic" (TW provider 14). These views reflected a fear among providers that failure to meet targets would threaten both current funding and the chances of being commissioned in the future. TW providers were anxious about meeting targets, as one provider said: "All these [resident] numbers all the time, you know, you're so focused on that" (TW provider 03). Providers were also anxious that money would be "snatch[ed] back" (TW provider 14) if they did not reach set targets. This fear was also reflected in the sense of competition that emerged between providers, discussed in more detail in the next chapter. Providers were concerned about the way in which targets were set, in large measure because they felt that targets in other projects might be easier to achieve. The emotional investment that providers had in their own project is shown in the quotation below from a TW provider at a mental health project:

> Changing an eating habit might be hard but you can basically wake up in the morning and choose whether you're going to eat chocolate or eat apples can't you? … You know, it's a choice … but if you're waking up in the morning not feeling particularly confident about yourself and not feeling that you belong in society … you've got no control over that, it's a much different process to move forward. (TW provider 14).

The fear of TW providers towards targets was also related to the fact that they had not contributed to their development. There was a perception among providers that unrealistic targets had been set for their projects because TW co-ordinators did not have an appreciation of what their achievement would entail. Referring to the resident recruitment targets, one provider at a physical activity project said "I think it's easy for people to set a target because whoever it was didn't know the area necessarily and didn't realise it really is hard to reach" (TW provider 07). A similar comment from another provider shows more explicitly that TW providers did not think that the people setting the targets had an understanding of the population that the providers were working with:

> So meeting the targets is the difficult part, doing the work with [residents] once we've [recruited] them isn't … targets are imposed on us as opposed to us being able to say, "You know what, it would actually work better this way round" … [My boss] negotiated down the [original] targets [suggested by TW co-ordinators], the targets were a lot higher. Now I think that didn't show any real understanding of mental health issues on [the part of] the people that put the targets in place. (TW provider 14).

TW providers also felt disillusioned with the evaluation process because there were problems with its organisation. TW co-ordinators did not develop an evaluation plan until after delivery had started and TW providers expressed frustration that the

delays in rolling out an evaluation process meant that some data had not been captured, as the following quotation shows:

> We kept getting told that there would be a regional or a national evaluation tool and monitoring database so we didn't want to be setting things up locally … We were hanging fire and we feel that perhaps some of the initial, early people have been lost in the recording. (TW provider 12).

There was also confusion among providers about the ways in which targets should be measured. Twelve months into the initiative, TW providers said that determining which residents could be counted as participants in the projects "is a really grey area" (TW provider 03). Providers were unsure whether they could count residents to whom they provided informal advice in a one-off meeting within their participant targets. A provider said, "I don't know whether you can [count such residents]" (TW provider 05). There was also some confusion as to whether children could be counted as beneficiaries of a project, given that the PHO evaluation tools were not designed for children. This issue was later addressed through the development of bespoke project evaluation tools developed by some TW providers to use in place of the PHO evaluation. These tools were developed from discussions between TW co-ordinators and providers in 2009. During the first 18 months of the project however, TW providers working with children were unable to collect data on the experiences of their participants and consequently some data were lost:

> The children … really do get something out of [the activities] and we can't count them as beneficiaries 'cause they are under 16 … And it's such a shame 'cause they really do, over the period of time we are in the school, benefit, they love it. (TW provider 08).

Changes to the target number of residents for each project on two occasions, instigated by TW co-ordinators in consultation with TW providers, contributed to further confusion among TW providers. A request was made by TW co-ordinators in April of 2009 asking TW providers to submit new targets for their project. TW co-ordinators suggested that this had been necessary because, in liaison with the funders, the co-ordinators had made changes to the ways in which project beneficiaries were defined. According to TW co-ordinators however, not all TW providers returned a new target for their project as, in their view, there was confusion over the information that was required. This was reflected in discussion at programme meetings, where TW providers expressed exasperation with the targets. Comments from the Programme Manager at one of the last programme meetings revealed that she did not have an up-to-date record of the targets for her projects. One TW co-ordinator said that "by June 2009 we had potentially four targets for

each project. Everybody, including ourselves, the programme leads, and the projects were totally confused and nobody knew what the targets were" (TW co-ordinator 02). Changes were being made by co-ordinators to the targets as late as December 2011, when some projects had spent their funding and finished delivering activities. Within *Grab a Bag*, the final target was changed to reflect the actual number of residents that had been engaged, demonstrating the extent of the confusion.

There was some resentment from TW providers that so much of the TW funding was apparently being used for evaluation. In addition to the main evaluation, TW providers were involved with, or at least made aware of, several other strands of research and evaluation, including the research for this study. A sample of projects across all of the BIG Lottery's Well-being Fund programmes, including one of the Ellesmere Port TW projects, were included in a national evaluation commissioned by BIG. In addition, a process evaluation was carried out across the regional TW portfolio by a research team at the University of Central Lancashire designed to capture processes that facilitated positive resident outcomes. Finally, TW co-ordinators also decided that projects should be allowed to develop their own type of evaluation, in place of the PHO evaluation, and subsequently a plethora of "bespoke evaluations" were developed within projects which used a variety of methods to capture feedback from users. The following quotation shows the frustration that was expressed by one provider that funds that could have been used to deliver activities had been allocated by TW co-ordinators to evaluation processes:

> Lots of money is going into research and evaluation, there are probably more people involved in the research and evaluation, and more money in the research and evaluation, than there are people on the ground doing the work. (TW provider 14).

TW co-ordinators revealed that TW providers had not been told to account for evaluation costs in their original budgets and that funds for the evaluation had to be taken from the projects' allocated funds after the initiative had started. One TW co-ordinator summarised the problems related to the roll out of the evaluation process in the following way:

> [Setting up the evaluation] was a bit messy … and there's lots of sort of unclarity [sic] about the rules and … perceived changing goal posts … There was a change in [the] definition of a beneficiary and … and then as a result of that, projects were asked to review their beneficiary numbers … We are 2 years on and the systems and structures still aren't properly in place. (TW co-ordinator 02).

In an evaluation subgroup meeting towards the end of the initiative, it was noted by one of the Programme Managers that "Programme Leads [managers] had not been involved in the commissioning of the NWPHO [to evaluate the initiative]" and that "the Programme Leads were unclear what the [PHO] brief was." There was general agreement at the meeting that "in hindsight, it [was] easy to see the Programme Leads could have been better involved in designing the evaluation tools". The confusion surrounding the evaluation, and their limited involvement in its development, made TW providers less confident that the pre-defined resident outcomes could be demonstrated.

7.4.3 Contextualised expectations of people

TW providers expressed expectations more focussed on individual experiences as an alternative to pre-defined targets. This was reflected in comments about how difficult it might be to change entrenched behaviours. The quotation below is illustrative of a widely held view among providers that small changes were the best that could be hoped for when trying to change behaviours that had been developed over many years:

> If you've got generations of families who don't eat 'five a day,' you coming along with a Target Wellbeing project, it's mental to think that you're going to have a massive impact on that because … you're not … small steps is all you can, sort of, do. (TW provider 09).

Their experiences with residents shaped TW provider expectations that it was difficult to capture changes with traditional evaluation tools. TW providers described changes that were visible to them because of their sustained involvement with an individual but perceived that such changes could not be captured through the existing evaluation processes. The quotation below, from a provider at a physical activity project, shows that TW providers demonstrated a different way of thinking about outcomes that was focussed on individual circumstances:

> We had a lady come … to [a physical activity event] which was fantastic, 'cause it was obviously a huge step for her, you know she'd got mental health problems … she actually came clutching this bit of paper … she said 'I'm looking for a Jo' and I said, 'That's me!' She said, 'Well, oh, my psychologist has given me your name.' So you can take her under your wing straight away and it was great and she had a great day. So again … it doesn't mean anything [in terms of targets] but it was a huge step for her. (TW provider 03).

Similarly, TW providers sometimes thought that they had helped residents to develop skills that might facilitate healthy behaviour at a later date but that these

were not reflected in the predefined outcomes. A TW provider working with people with long-term mental health problems to develop confidence and self-esteem said "measuring soft skills is just impossible" (TW provider 14). Another provider described how such skills would be lost within the current evaluation process:

> We've developed a skill set … So I don't know whether our intervention, in that sense, can count … they're not actually gaining anything other than the skill set, they're not gaining any health or wellbeing that we can measure or that we can monitor. There's no outcomes there. (TW provider 03).

There was a perception among TW providers that the evaluation questionnaires were inappropriate for the target audience and hence damaging to the development of positive health changes. There was a perception that the evaluation was "detrimental to what else [was] going on" (TW provider 09) within a TW activity as the processes could potentially damage rapport with residents. Based on feedback from TW providers, TW co-ordinators developed the view that "the tools don't work for the vast majority of service users 'cause they are too long and they are too inaccessible" (TW co-ordinator 02).

Outcome targets were seen as unhelpful by TW providers because they deflected TW providers from their work with people. Providers at a mental health project perceived that because the course of change for people with long-term mental health problems was unique to an individual's experience, working towards predefined targets could be detrimental to helping people develop in a positive way:

> When you're just focused on the target you're not working within the client's needs, you know, you're just trying to push people through a system and so you often miss the outcome, does that make sense? (TW provider 14).

Similarly, providers held a view that working to engage a large number of residents in an activity was less worthwhile than facilitating sustained changes among a small number of people, as the following quotation illustrates:

> I have never sat there and gone, "Right the aim must be that we achieve these … numbers" because it's totally meaningless …I just don't see the value in spending time sort of box checking when, wouldn't it be better to have four people who are planning on a regular basis of spending time outside with their families [involved in physical activity?] (TW provider 09).

Further differences between provider and co-ordinator expectations are examined below.

7.4.4 Future gains: better co-ordination between services

TW and non-TW co-ordinators had an expectation that collaborative working would develop among providers working in the town through the TW funding. They anticipated that TW providers would "work really closely together" (TW co-ordinator 02) to embed their work "within a wider … network of health projects" (TW co-ordinator 05). A number of networking activities were set up by TW co-ordinators to encourage this. A Regional Support Network (RSN) run by TW co-ordinators was set up to "act as a co-ordinating body for local … activity, linking related interventions within the portfolio, and ensuring that projects are not delivered in isolation" (Strategy document p. 23). The Programme Managers were also given a role to help TW providers "to try and fit in to an overall [service provision] strategy" (TW co-ordinator 02). They were encouraged by TW co-ordinators to do this through monthly 'programme meetings' between TW providers working in the same target area which were stared in Ellesmere Port in July 2008. One TW co-ordinator described the anticipated collaboration between providers in the following way: "The whole thing was set up to be a regional strategic portfolio so it is all about the projects, like working collaboratively and providing collaborative benefit" (TW co-ordinator 02).

These expectations were accounted for in the following ways by TW co-ordinators. First, collaboration was associated with better success for TW providers in terms of reaching set target outcomes. There was an expectation that collaboration would lead to better use of resources, such as facilities and staff. TW and non-TW co-ordinators and providers associated co-ordinated working with better use of resources based on "economies of scale" in terms of pooling resources (TW co-ordinator 01; TW co-ordinator 04). One co-ordinator described how this might facilitate the engagement of a larger number of residents than might be achieved by TW providers working in isolation:

> Putting projects on together … or … having an event … where you're gathering together beneficiaries … so only one lot of advertising … you're getting more [residents involved] for less money. (TW co-ordinator 01).

There was an expectation that joint working would enable TW providers to disseminate a "clear message" to local residents about the aims of the initiative (Non-TW co-ordinator 05) which would raise the TW profile locally. Furthermore, within the funding bid, co-ordinators claimed that the initiative provided an opportunity to share information between providers about "what works" in achieving

the programme's targets (TW co-ordinator 01). One co-ordinator described how information from TW providers about their experiences could be used to influence the way in which a particular activity was run at another project:

> That's how you learn, you go to other different projects and you see how they are doing things … it would really help the project that has got less resources and less people working on it to see a project that's up and running, to see what sort of issues they've had, what works well, what doesn't. (TW co-ordinator 01).

TW co-ordinator ideas about collaboration were therefore closely associated with their vested interests in demonstrating wide-scale change to current and potential funders.

Second, these expectations reflected a desire among TW co-ordinators to be involved with, or to commission, future work in the area from the VCS. TW co-ordinators and providers held a view that collaboration would lead to increased capacity and capability of the VCS to deliver services in the town in the future through "cross-fertilisation of ideas and support [for] each other" (TW co-ordinator 04). According to TW and non-TW co-ordinators, there was a particular need to develop collaboration between VCS providers in Ellesmere Port because, as already mentioned, they perceived that the VCS was "not well developed" in the town (Co-ordinator 04). TW co-ordinators suggested that the initiative presented an opportunity to demonstrate the health outcomes of existing VCS work to future potential funders. One TW co-ordinator, based within the VCS, said it was an opportunity to demonstrate to funders, "what the third sector can do" (TW co-ordinator 05). Within the regional bid document submitted to BIG, developing the capacity of the VCS was identified as a key outcome for the initiative:

> We will also develop local well-being capacity, and specifically support the Voluntary & Community Sector to showcase the extent to which they can contribute to improving wellbeing. As a result we expect the Voluntary & Community Sector to be considered a viable and credible mechanism though which to deliver mainstream public services. (Northwest Wellbeing Partnership, personal communication, February 21, 2007, p.9).

One TW co-ordinator suggested that collaboration between VCS providers was essential to the survival of VCS organisations in the face of potential funding cuts, claiming that "united we stand, divided we fall" (TW co-ordinator 02). Within the Ellesmere Port bid, it was anticipated that VCS involvement in TW would encourage future collaborative funding bids within the VCS and increase the local VCS's

“capacity and ability to expand, and enable them to benefit from future opportunities previously beyond their reach” (Local bid application p. 13). Within Ellesmere Port a training session was set up by TW co-ordinators to encourage TW providers to explore ways in which they might bid together in the future. There was, therefore, an expectation that improved co-ordination between VCS organisations would improve the likelihood of more funding for the area in the future.

These expectations were not shared by TW providers. Although some TW providers said that working collaboratively with other TW providers might be “beneficial”, they did not articulate ways in which their organisations might benefit from it (TW provider 09). The account that follows in the next chapter, of the ways in which relations between TW providers developed, provides an explanation for these contrasting expectations.

7.5 Conclusions

This chapter sought to examine the processes through which providers and co-ordinators were brought together to deliver TW. It also examined how these processes (which formed the wider social context in which these people were working) shaped expectations among these groups in relation to TW activities. The interpretive account revealed that the process of commissioning organisations and staff to deliver TW was shaped by power relations between co-ordinators and providers. These balances influenced who was selected to deliver and manage TW activities and pushed some people towards the periphery of the developing network. The maintenance of power balances in the development of the management structure limited the capacity of some people to influence the strategy for TW.

Different expectations about the initiative were expressed by TW providers and TW co-ordinators, which can be better understood with reference to the different social contexts in which such expectations were formed. Partly as a result of their dependency on statutory and VCS funds to continue their work, TW co-ordinators had developed ways of working which enhanced their chances of obtaining future funding. The development of targets among this group and expectations around collaborative working can be better understood with reference to their emotional investment in demonstrating change in the areas in which they worked. TW providers on the other hand, perceived individual targets for their organisation as a threat to the ways in which they worked with residents and perceived that failure to

meet such targets would threaten their chances of obtaining future funding. Their isolation from the process of target setting made them resentful of the targets and more inclined to value consequences that reflected their own experiences working with residents. The ways in which early relations and expectations influenced the development of TW activities is discussed across the following three chapters.

Chapter 8

Service provider relations

8.1 Introduction

The purpose of this chapter is to examine the ways in which relations between providers developed once TW funding had been obtained. Findings from the previous two chapters inform understanding of the processes that facilitated and constrained collaboration. Analysis of data relating to collaborations between providers is used in the first part of the chapter to describe the relationships that developed over the course of the initiative, which provides a backdrop against which to examine qualitative data relating to service provider and co-ordinator experiences. A number of concepts were developed to explain how service provider relations developed over time; this part of the chapter is organised by these ideas.

8.2 Developing networks between service providers

Several dimensions of the relations between TW provider organisations influenced the ways in which relations developed. New or existing staff were appointed to deliver TW activities within each organisation. In some instances, these staff had also been appointed to deliver other projects run by the organisation, funded through other sources. The social and physical dynamics between the organisations that emerged as significant in the development of relations are outlined in Table 8.1. Some organisations had a history of working in the town but had not delivered services there in recent years because funding had required the organisation to work elsewhere. In some instances, although the organisation for which they worked had a history of working in the town, some people employed solely through the additional funding that TW brought did not. Five of the projects chosen had been designed for TW by providers at the relevant organisations; the remaining three projects were already being delivered in other geographical areas. Consequently, all of the TW providers were delivering activities or services that had not recently been delivered in the town.

Table 8.1 Social and physical dynamics between Target Wellbeing organisations

Sector & geographical remit	Physical location	History of service delivery in the town?	Delivered newly created or existing project(s) within TW?
County branch of a national charity	Within the town	Yes	Newly created project
Charity serving local authority area	Approximately 3 miles from the town	Yes	Existing project
County branch of a national charity	Approximately 20 miles from the town	No	Newly created projects
Charity serving neighbouring city	Approximately 16 miles from the town	No	Existing project
Statutory funded health centre	Within the town	Yes	Newly created projects
Community interest company serving nearby town	Approximately 30 miles from the town	Yes	Existing project

Data generated through observation methods can be used to form a picture of the provider network as it developed throughout the case study period. At a programme meeting almost 18 months after funding had been allocated to TW providers they were asked, as part of this research, to list organisations with which they had collaborated. Collaboration was loosely defined for this exercise as working with others for the purposes of TW activities and could include TW or non-TW providers. TW providers were asked to define their relationship with identified providers, which after analysis, could be categorised as predominantly relating to one of the following: sharing financial resources, sharing other resources, or referring residents between services. The relationships between providers developed by April 2009, over a year after TW funds had been allocated, are shown in Figure 8.1. The colour of the text box for each organisation denotes its sector (as defined within their own publicity materials); the colour of the arrows between organisations denotes the type of relationship between the two organisations and arrow heads denote whether resources or service users were referred to or from TW providers. The TW providers are shown are designated by larger text boxes.

The image of provider relations described through this analysis is limited as it does not capture any information about relations between people (only organisations and projects), and it does not capture how relations developed over time or their relative importance to providers. Notwithstanding these limitations, the picture reveals something of the complexity of the relations that developed over the period of the case study: it shows that providers at numerous organisations were involved in some way in TW activities and that TW providers worked with some of the same organisations in the town. The diagram indicates that, at this stage of the initiative, TW providers predominantly worked with other statutory organisations rather than VCS or private organisations and that these relations were predominately related to the referral of service users. It also shows that few TW providers worked with community volunteers. Despite the expectations of TW co-ordinators, few of the TW providers identified one another as collaborators. These findings can be better understood with reference to the themes developed out of the qualitative data, discussed below.

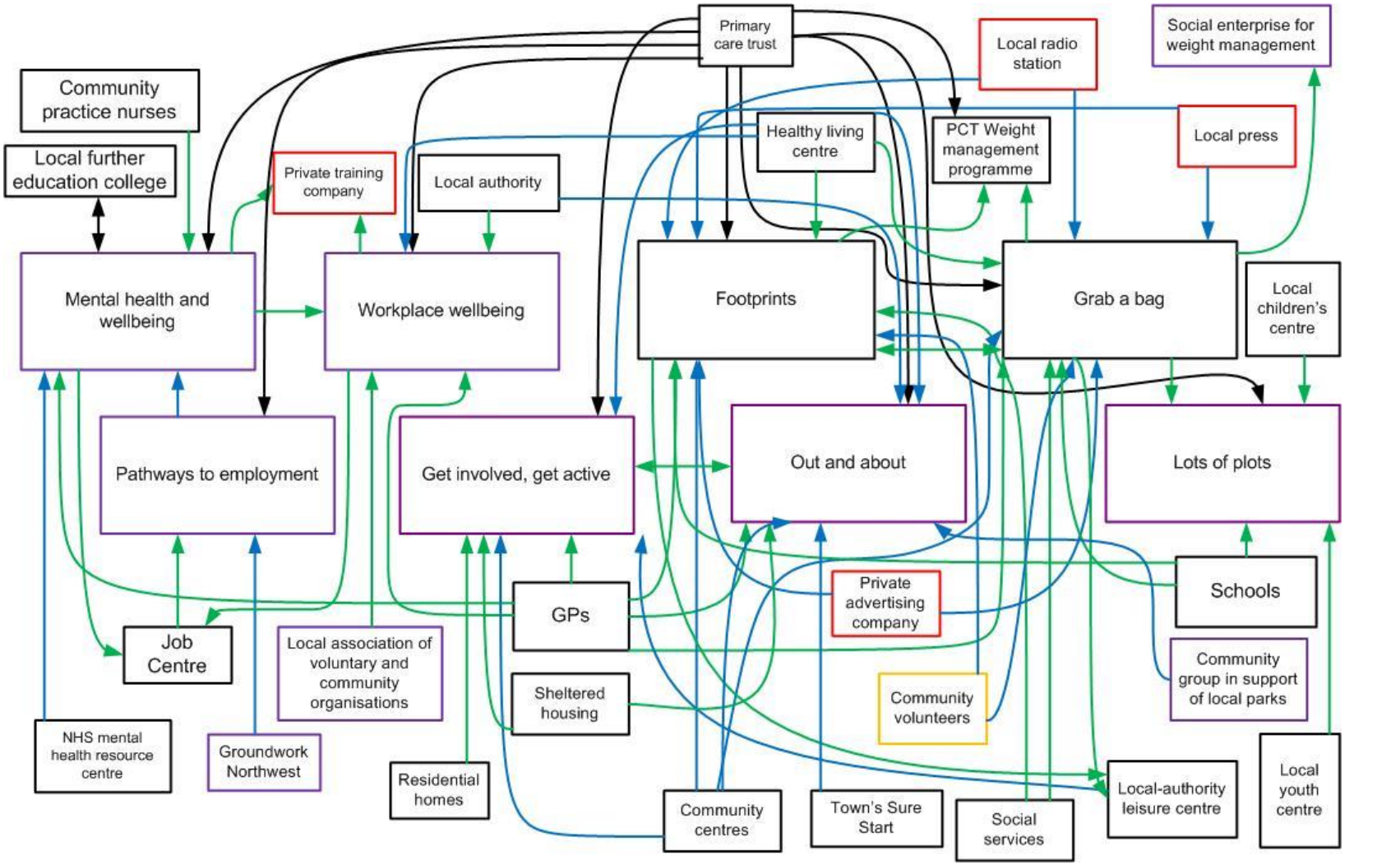


Figure 8.1 Relations between Ellesmere Port providers: April 2009

Analysis of data from monthly monitoring reports, minutes from programme meetings, and field notes provide some insight into the ways in which the provider network developed over time. These data sources were used to compile a list of organisations with which TW providers had worked across the period of the case study. This analysis showed that TW providers were developing collaborations with other providers 3 years after funding had been received. By the end of July 2010, TW providers collectively had collaborated with 94 different organisations. By the end of July 2011, this number had risen to 102. Different departments within the PCT and the local authority were categorised as separate organisations in this analysis in order to reflect differences in both the type of work carried out across different departments and their geographical location in the town. A limitation of this analysis is the inability to capture whether or not collaborations endured over time, as these data were not recorded in any of the documents analysed. This issue was examined however using qualitative methods and is discussed in section 5 of this chapter.

Analysis showed that different TW providers worked with a number of the same organisations. All TW providers worked with staff at the Healthy Living Centre, where two of the TW projects were based; providers at seven of the TW projects worked with teams at Cheshire West and Chester council and providers at four different projects worked with a VCS co-ordinating organisation. A number of TW providers worked with the same schools and residential care homes. The ways in which these converging relations developed are discussed in the sections below.

In order to examine the geographical spread of collaborating organisations, their postcodes were mapped using GIS software. A small number (19) of these organisations were based outside of Ellesmere Port. Table 8.1 shows the number of organisations with which TW providers at each project worked and how many of these were based outside of Ellesmere Port. This included TW and non-TW provider organisations.

Table 8.2 Organisations with which each Target Wellbeing project had collaborative links: 2010-2011

Project name	Total no. of collaborators	Non-Ellesmere Port collaborators
Health at Work	24	2
Lots of Plots	24	0
Mental Health and Wellbeing	19	6
Get Involved, Get Active	16	3
Out and About	16	0
Pathways	13	0
Footprints	12	0
Grab a Bag	9	0

Providers from *Lots of Plots* and *Health at Work,* two organisations based outside of the town and new to the area, worked with the largest number of collaborating organisations and providers from *Grab a Bag,* located centrally and working at an organisation with a history of working in the town, worked with the smallest number of organisations. Providers within *Mental Health and Wellbeing* worked with the largest number of organisations based outside of Ellesmere Port. Figure 8.2 shows the location of the providers in Ellesmere Port with whom TW providers had worked at two points in time; July 2010 and July 2011. Each plot on the map represents a collaborative relationship with a TW provider; organisations collaborating with more than one TW organisation are plotted more than once. Collaborations formed after July 2010 are shown in blue. The majority of organisations with which TW providers collaborated were based within the target wards, with a large proportion based in Central Ward, where, according to the analysis in Chapter 5, most services were based.

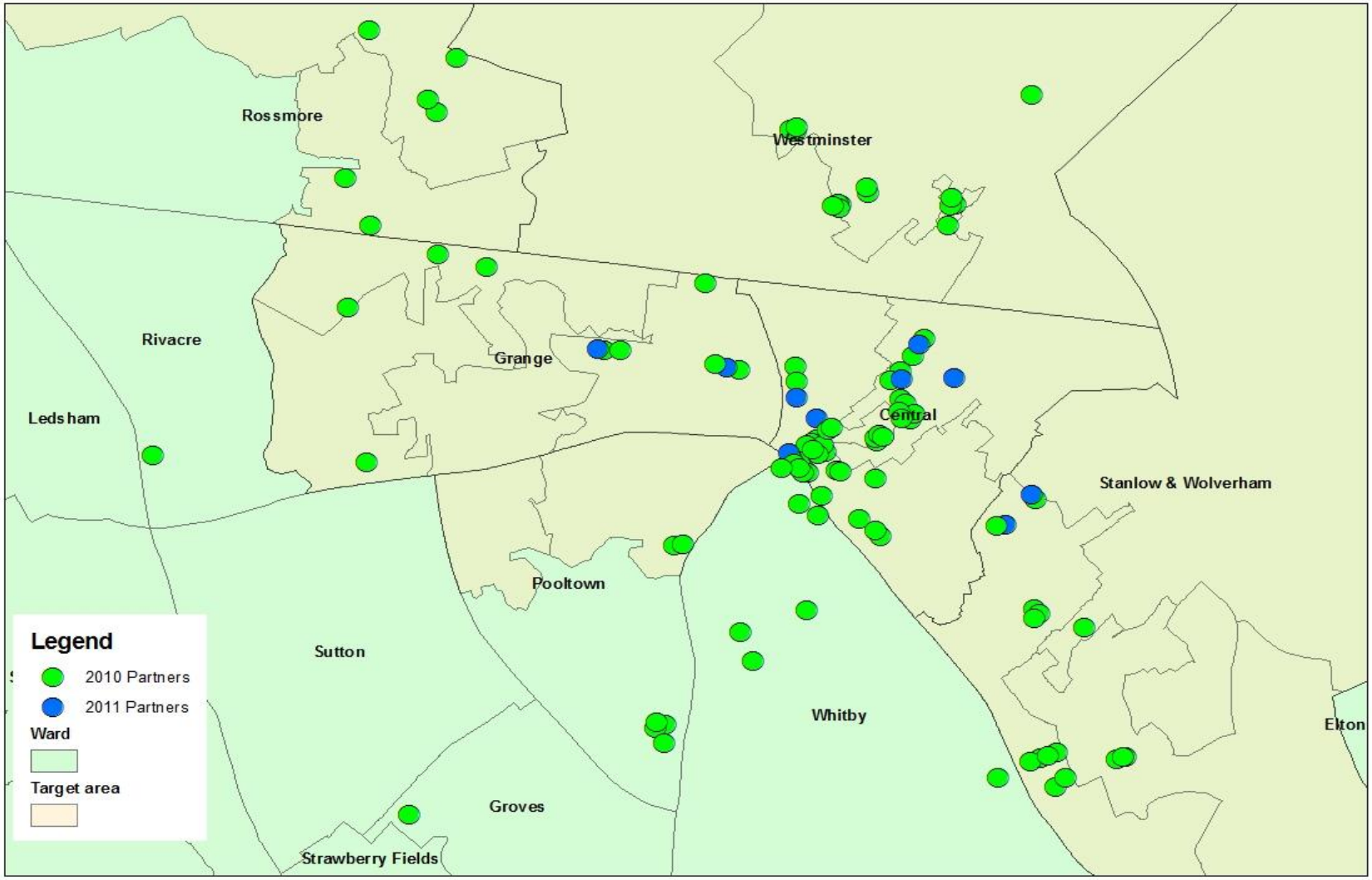


Figure 8.2 Target Wellbeing partners July 2010 & 2011 © Crown Copyright/database right 2011. An Ordnance Survey/EDINA supplied service

There were differences between TW providers in terms of the geographical location of their collaborators. Figure 8.3, shows the location of the organisations with which each TW provider collaborated at the end of July 2011. Providers at *Health at Work,* based outside of the town and new to working there, worked with the largest number of organisations based outside of the target wards (4) but, as they worked with a high number of organisations overall, these providers still had the second highest number of collaborating organisations within the target wards. The GIS analysis shows that for providers at some TW projects, their collaborators were concentrated in a small geographical area. Providers at *Pathways* for example, worked with only one organisation outside of Central Ward. Providers from *Lots of Plots* and *Out and About* (projects delivered from within the same organisation) were the only providers to work with organisations in every target ward of the initiative.

Having described the differences in collaboration between providers at different TW projects it is now possible to examine possible explanations for these based on qualitative analysis of providers' experiences.

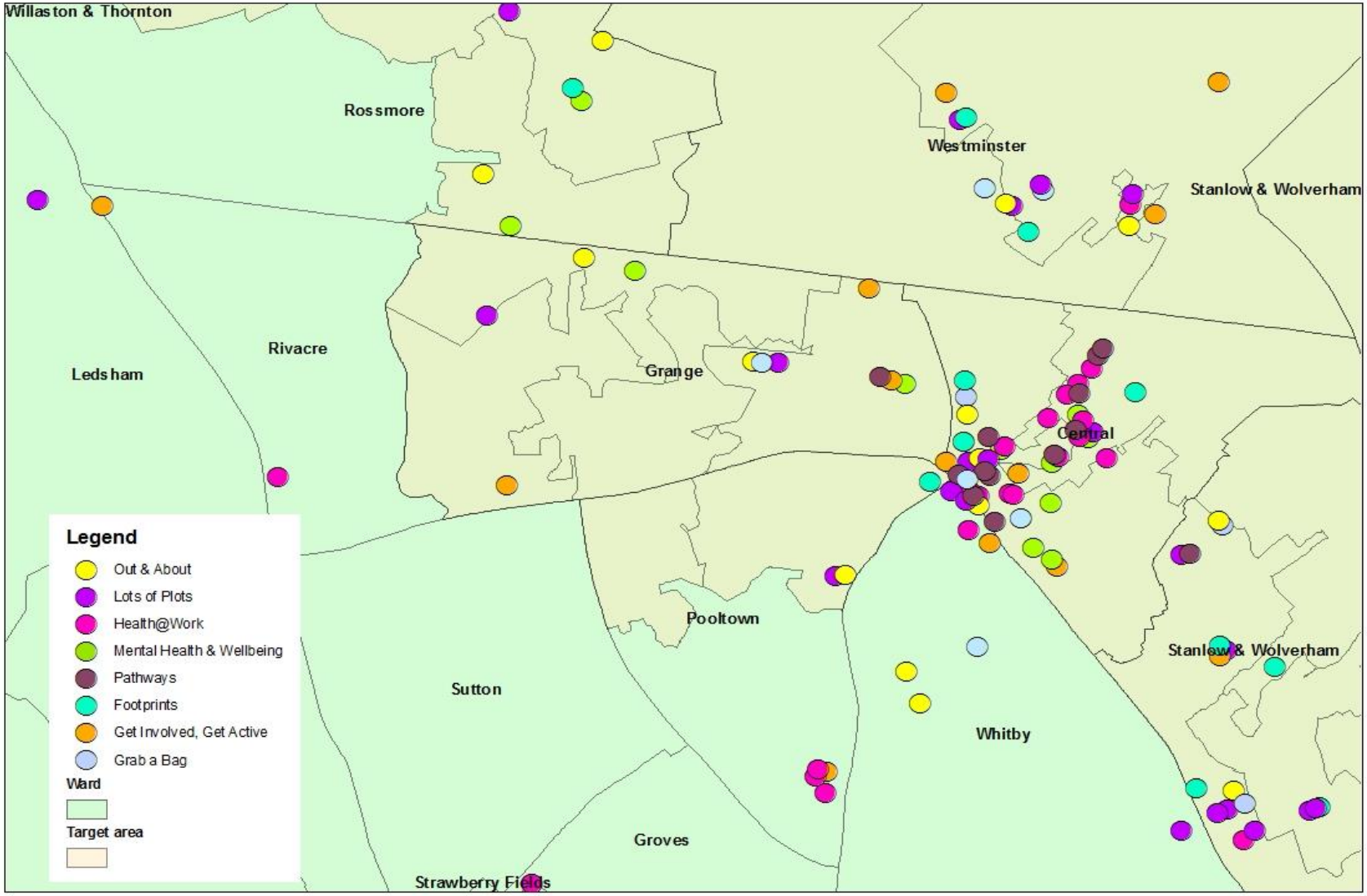


Figure 8.3 Target Wellbeing partners by project July 2011 © Crown Copyright/database right 2011. An Ordnance Survey/EDINA supplied service

8.3 Organisational pull

The analytic concept 'organisational pull', which emerged from the qualitative data, captures the way in which TW providers were interdependent with others in their own organisation, which constrained their capacity to work collaboratively with other providers. These interdependencies had been formed over many years. The concept reflects the way in which providers' shared experiences influenced their outlook and expectations. One way in which organisational pull could be understood was through the idea of a shared organisational outlook.

8.3.1 Shared organisational outlook

Organisational pull captures the ways in which interdependencies between staff within the same organisation shaped their expectations in similar ways. Established relationships with colleagues in a particular field perpetuated a sense of commitment to a particular organisation and there was a perception among some TW providers that the comparatively small number of employees within some organisations also made them "close knit" (TW provider 15). A shared commitment to the mission and values of their organisation emerged from these close knit relationships. One TW provider, who had worked at the same VCS organisation for 10 years, supporting people with mental health problems, perceived that it was "really good" that her organisation had "never strayed from the mission statement" (TW provider 14).

Even TW providers who had been recruited to organisations for TW work (and so had less established relationships with people in their organisation) had a shared organisational outlook with their colleagues. This seemed to partly originate from similar experiences working in a particular field or with a particular client group. TW providers expressed a sense of pride in the shared expertise held by people within their organisation in relation to supporting specific client groups. One provider said that before their involvement in TW, staff at her organisation had "been working on unemployment projects, in previous [roles] for about ten years" (TW provider 13). Association with a particular area of expertise shaped the way in which providers defined their professional identities. Consequently, staff identified more closely with the specialist organisations in which they worked than with TW more generally, as this enabled them to maintain their professional identity. One TW co-ordinator commented that the TW providers "see themselves as … a member of [their organisation] …as opposed to, "I'm a member of Target Wellbeing"' (TW co-ordinator 01). In this respect, the identity of TW providers was shaped by a history

of social relations with people in a particular field, and sometimes, within the same organisation.

Organisational pull shaped providers' perspectives on priorities for service delivery in the town. Notwithstanding the differences already identified between providers in the same organisation towards the strategy for their project, staff at the same organisation tended to hold similar views about the purpose of the activities they were delivering. In some instances, where an organisation did not have a history of working on health-related projects, these views did not necessarily reflect the overall aims of TW. Discussing the work of providers at an organisation with a mission focussed on developing community skills, one TW co-ordinator expressed a view that aims were compatible, but not necessarily driven by the same aims:

> Our walking and cycling projects weren't really directly designed with health in mind. They were designed because [people at the organisation] think it's a good thing for people to do more cycling [for enjoyment]. (TW co-ordinator 05).

In addition to shared professional experiences, TW providers tended to have experiences in common with their service users, which shaped their commitment to the client group with which the organisation worked. One TW provider, for example, described how her work with young people at a mental health organisation was shaped by her own low self-esteem as a young woman. In these instances, as well as instances where providers had a long history of working with a particular client group, past experience had shaped providers' views about the priorities for services in 'deprived' areas. Providers at different organisations did not always share the same priorities and this influenced the extent to which they thought that they could work together. One TW provider perceived that collaborative working across TW projects was difficult partly because "other [providers] [were] all delivering their own agendas" (TW provider 12). The historically constituted social identities to which TW providers subscribed were therefore defined against other identities in the town.

Influenced by a shared habitus, staff at the same organisation were drawn to work together. Analysis of observation and documentary data above indicated that TW providers working on different projects at the same organisation worked together more frequently than did TW providers across different organisations. TW providers working on different TW projects within the same organisation reported working as "one big team" within their own organisations (TW provider 12) and, from the point of view of co-ordinators, "seem[ed] to merge together" (TW co-ordinator 01). This,

among other things, explains why collaboration with other TW providers was not always actively pursued. Collaboration was more likely to be with others working in the same field who had similar priorities.

8.3.2 Shared investment in the future of the organisation

Organisational pull also reflects the way in which TW providers were drawn to work together because of their greater dependence on one another for future work. Although many TW providers were employed through short-term TW funding, there was an expectation among them that should the organisation secure more funding, this might enable them to secure more paid work. TW providers described securing future funding for their organisation as motivation for their work and this shaped the way in which they approached relations with other providers. One TW provider from an organisation based some distance from the town said, “We want to develop links with [the town] and develop new projects from our contacts” (TW provider 02). TW providers were keen to ensure that developing relations facilitated their own work in a particular field. In this respect, their interdependency with others in their own organisation shaped their relations with those outside of it.

Organisational pull reflects the way in which providers at the same organisation perceived that other providers posed a threat to the future success of their organisation. This was exacerbated by the actions of other people in the figuration. For example, the introduction of individual project recruitment targets by TW co-ordinators heightened the sense of competition between TW providers. These targets were regarded by many TW providers and co-ordinators as an important measure of success. This was partly shaped by the fact that, despite reassurances to the contrary from the funders and TW co-ordinators, some TW providers were fearful that their funding would be withheld if they failed to achieve these targets. One of the TW co-ordinators suggested that this uncertainty stemmed from previous experience “of having money clawed back”, having failed to reach targets in other initiatives (TW co-ordinator 01). Several TW providers expressed a fear that engaging in joint activities with other TW providers might threaten achievement of their own organisation’s resident recruitment (or project “beneficiary”) targets as the following quotation illustrates:

> I just don’t think we’re talking to each other as well as we could in terms of projects. And I think part of that is the fear of crossing over beneficiaries because we don’t quite understand whether, if we have some beneficiaries, whether another project can come in and do what they do and still count them as beneficiaries for them, or

> whether we have to go away and they count them as beneficiaries. (TW provider 02).

Several interrelated social processes developing beyond the town also influenced the extent to which providers were drawn towards others within their own organisation. The global and national economic crisis of 2007, an LGR in 2009 and a change in national government in 2010 influenced an increasing sense of job insecurity among TW providers across the course of the initiative. When interviews took place in 2009, providers described the context in which they were working as a "transitional phase" (Non-TW provider 01) and described the survival of their organisation as a priority in their work during this period. One non-TW provider said: "It's just a question of getting through it" (Non-TW co-ordinator 02). Securing future funding for the organisation in which they worked was therefore a priority for TW providers. The deeply-rooted behaviours and attitudes of key personnel within each organisation interwoven with the actions of others in the figuration, as well as more complex social processes involving people at a regional and national level, constrained the ways in which TW providers approached relations with providers outside of their own organisation.

Although organisational interdependencies had a strong influence on providers in the early stages of the initiative, as relations are dynamic, over time other processes emerged that mediated the influence of these interdependencies. Analysis of observation and documentary data indicated that TW providers across different organisations shared more information about their work with one another over time. This was particularly evident at quarterly programme meetings, where TW providers offered more details about their activities at later meetings. During one of the last programme meetings, staff whose project targets had been met discussed how they had felt more inclined to work with TW providers at other organisations once they had begun to achieve these targets. These findings indicate that the ways in which providers are interdependent will change over time, creating opportunities for new alliances between providers to form. Other processes that mediated organisational interdependencies will now be discussed.

8.4 Local status

The development and use of 'local status' were processes which influenced the balance of power between providers in the figuration. Being 'local' was expressed by providers and co-ordinators as having one or more of the following attributes:

living locally, having an established history of working in the area, or working from a local office base. The emphasis that research participants placed on each of these attributes in their definition of 'local' depended on their own social location within the town. TW and non-TW providers and co-ordinators associated local status with a number of positive characteristics. Unpacking the particular dimensions of the concept local status and the circumstances under which it became important provides insight into the ways in relations developed over time.

8.4.1 Empathy with residents

Local status was associated with having a good understanding of the population targeted by the initiative. This understanding was considered to be valuable by TW providers because, it was explained, it was used to inform the development of activities and recruitment methods within projects. One TW provider explained that she had sought to appoint people who "live[d] in … local wards" to deliver TW activities because they were more likely to have local knowledge (TW provider 12). Others commented that living locally gave providers greater insight into what the community needed. Discussing why VCS organisations were recruited to deliver TW, one co-ordinator intimated that they were often closer to local residents than other providers:

> Often [VCS organisations] are within a community … [they have] offered local services for local people and the local people talk to other local people and there's much more of an understanding … a community identify needs rather than organisation[s] identify[ing] needs. (TW co-ordinator 03).

Local status was also associated with caring more about resident needs. The following quotation, from a non-TW provider at an organisation based in the town, demonstrates how local status was associated with having an investment in the people in the town:

> I think [TW] should have been more local than maybe it was … it's difficult if you're not a local organisation to come in and deliver [and also], do they care? … I mean I do what I do here and I care about it because I live here and my family lives here, I want there to be good services, you know … If I didn't live here, would I care in the same way or would it just be about the money? (Non-TW co-ordinator 02).

Reflecting the way in which local status was formed among residents, local status was defined by providers in opposition to 'outsider' status which was sometimes associated with poor understanding of residents' needs. Some non-TW co-

ordinators in the town were critical of TW staff at an organisation based several miles away for failing to recruit residents to some of their activities, a failure that one co-ordinator attributed to the organisation's location. Despite acknowledging that recruitment problems had also been experienced within a 'local' TW organisation, the same co-ordinator described "everything" this organisation delivered as "really good" (Non-TW co-ordinator 02), indicative of the extent to which 'local' status influenced perceptions of service quality. Related to this, 'outsider' providers were seen to pose a threat to the position of those based in the town. Some non-TW providers, for example, expressed agitation that organisations based outside of the town had been chosen to deliver TW projects. A staff member at one such TW organisation described how providers based in the town had expressed doubt that they would succeed in recruiting residents to activities:

> The initial feedback from coming here was: there was no chance we would be able to do the programme [successfully] because the other people actually based in the [town and delivering similar programmes] have had no response [from residents]. (TW provider 01).

A TW provider who had recently moved into the town felt that people who had lived in the area longer than she had were better able to explain resident behaviour than she was. She said that this was because "as an outsider, you don't know [what's] true … I've only been here a couple of years, so I don't know" (TW provider 03). This indicates that some providers accepted their status as outsiders as well as the characteristics associated with this label.

8.4.2 Legitimate claims to resources

Local status was related to a sense of legitimacy in terms of accessing resources from non-TW providers. Tensions between funded providers and providers working in the town who had been unsuccessful in their TW bids, or not invited to bid, were reported. Providers at an organisation unsuccessful in its bid were reported to have voiced their unhappiness to others working locally that TW providers were dependent on them for resources. These resources included resident information and facilities that were used in the delivery of their TW projects. One non-TW co-ordinator described what had taken place:

> [One organisation] was very upset that … they'd been kicked back [for funding] and they're even to this day massively cheesed off because a lot of the [TW] projects that are … saying how excellently they're doing are still … relying heavily on [them to run their projects]. (Non-TW co-ordinator 05).

Cultivating local status was a strategy used by some TW providers to lever access to support from other providers in the town. TW providers sought to develop relations with non-TW providers in the town who were important in helping them to develop and maintain their project activities through the provision of resident referrals, local information and facilities for TW activities. TW providers and co-ordinators articulated a view that being seen as local made other 'local' providers more inclined to share these resources. For example, TW providers whose organisation had connections with other providers in the town revealed this to people with whom they wanted to work. The quotation below from a TW provider illustrates this well:

> [My project] is … already joining something that has a local reputation … that has links … with both the PCT and the council, so it's not a new project completely on its own setting up and having to find its feet, it's joining something that's already established within the local area and I think that that gives it a real advantage …. to give [the project staff] some credentials, really, particularly when going into schools and speaking to teachers, they don't just want anybody coming in and working with their pupils. (TW provider 12).

Local status was cultivated by the ways in which providers worked with one another. TW providers with experience of working in the area revealed that, in some instances, they preferred to refer their service users to non-TW providers with whom they had established relationships than to other TW providers with whom they did not. One TW provider stated that:

> We will introduce [our users] to places like [non-TW provider] and we will work very closely with them … we've never really been able to engage with [one of the TW projects] … And [the non-TW provider] will stay longer with our [users] because of the working relationship we've got with them … So with the [TW project], I don't know, I think that our [users] wouldn't be ready for them and when they are ready for them, there are probably other organisations that we already work with. (TW provider 14).

Referring residents to 'local' providers with whom they already had an established relationship perpetuated a provider's status as local and served to limit the extent to which other providers could access resources.

Such was the perception that being 'local' was an advantage that one TW provider accounted for the difficulty she had in establishing relations in the town by wrongly assuming that her organisation was the only one that was not 'local':

> All of the other TW providers are all based locally … we are kind of on a tangent so … I don't think really, apart from the meetings and bumping into people at events … we don't really have that day-to-day contact with all of the other TW service providers. (TW provider 05).

This indicates that local and outsider status was used effectively to push some providers towards the periphery of the emerging provider network in the town.

8.5 Earning one's stripes

Outsider status was not fixed but, rather, was part of a fluctuating balance of power between providers. Thus, local status could be earned over time, particularly through developing relations with others who were deemed to be local. Reflecting the quantitative data analysis above, TW providers described how their networks with non-TW providers had grown in size over the course of the initiative and how this influenced their status as local providers. The processes through which the balance of power between providers shifted over time are examined below.

8.5.1 Developing a project niche

The development of niche activities by TW providers, which did not overlap with existing provision, facilitated the development of relations with non-TW providers. This process helped to ease the sense of competition between providers. In some instances, TW providers working in similar fields were wary of one another. At a programme meeting in 2010 one provider at a mental wellbeing project privately quizzed the researcher about the work being done in another mental wellbeing project but did not speak to the provider from that project directly either at that or other programme meetings. One TW co-ordinator reported that she had expected two TW providers focussed on similar issues to work together more closely. One provider had a long history of working in the town while the other did not. The co-ordinator perceived that staff at these two organisations had not understood each other's work, which, along with the sense of competition they felt, had made them suspicious of one another:

> They were both probably seeing quite different clientele [but] they didn't understand each other … well [enough] to actually understand that, and saw each other as competitors rather than being able to offer each other business. (TW co-ordinator 04).

Over time, some TW providers made changes to the activities that they were delivering because they perceived that there was overlap with their provision and that of other TW and non-TW providers in the town. For example, one TW co-ordinator described how, initially, a number of walking groups in the town, run by TW and non-TW providers, "found that they were all overlapping" (TW co-ordinator 01). This co-ordinator perceived that the TW providers had since "found their own niche" and had been able to adapt what they delivered to fit with existing provision (TW co-ordinator 01). One TW provider at an organisation based outside of the town had altered the workplace activities she delivered to focus on wider aspects of wellbeing. She described how the process of change came about in relation to other service provision in the town:

> We've recognised our niche … I think, in [the town]. And we didn't recognise that to start off with, … we knew it would be difficult to engage in a new community ... So we knew we'd have problems getting ourselves known but I think what we didn't realise was where we sat in it, and we do now, we have a strong identity of who we are in the provision of welfare support in [the town]. (TW provider 13).

Where TW providers were able to adapt what they delivered to fit with the perceived needs of 'local' providers this facilitated the development of positive relationships between them. TW providers based outside of the town were more likely to adopt this strategy. One TW provider, for example, described how "fitting in with their agenda" made it easier to access support from non-TW providers in the town (TW provider 10). This can be understood with reference to the sense of competition between providers in the area. The development of a specific niche for TW activities removed some element of competition between providers and increased the likelihood that TW providers could offer something to the clients or users of non-TW services. This illustrates the way in which 'local' providers were able to use their status to influence what was delivered within TW, how it was delivered, and by whom.

8.5.2 Informal face-to-face meetings

Informal face-to-face meetings facilitated the development of trust between providers through the sharing of information and this influenced the development of co-ordinated activities. This was partly because such meetings enabled TW providers to talk away from the scrutiny of TW co-ordinators. In the early stages of the initiative TW providers were wary of reporting, in a formal setting, any issues that might indicate a problem with their ability to reach targets. Analysis of minutes

and observation notes showed that it took 18 months of TW meetings before any TW providers requested help from other TW providers at a programme meeting with a problem experienced at their project. At this time, as discussed above, most providers were more confident about their ability to meet recruitment targets. Some TW providers had little knowledge about some of the activities or people working within other TW projects even after several months' involvement in the initiative. During interviews that took place almost 2 years after the allocation of TW funding, one TW provider said that "some of the projects we don't know particularly well" (TW provider 09) and another, that it was "really hard to get your head round [the whole programme]" (TW provider 07). TW co-ordinators perceived that this affected the "level of trust" between some TW providers (TW co-ordinator 04). This illustrates how the complex interweaving of individual actions constrained the ability of TW co-ordinators to shape co-ordinated working between TW providers. The sense of competition between providers, influenced by the development of beneficiary targets, limited the capacity of TW co-ordinators to shape co-ordinated working through planned networking events.

Informal discussions, by contrast, enabled providers to find out more about one another. Informal discussion between some TW providers often took place at the end of programme meetings. A TW provider based outside of the town described how formal TW networking opportunities, organised by TW co-ordinators, limited discussion between TW providers. He perceived that informal meetings were more effective for establishing working relationships with other providers:

> I think the [programme] networking meetings, to be honest, we're a bit scared of talking … you do feel that it's a bit of a reporting session to [the Programme Manager], to be honest … and I think that's not helpful. The networking that I've certainly done with other projects has been outside the meetings or over tea after the meeting. (TW provider 02).

Informal face-to-face contact with other providers also enabled TW providers to convey a sense of commitment to the town and to convince other providers that they had a legitimate claim to resources there. Having a local office base was associated with 'local' status by some providers and informal face-to-face contact with other providers was one of the ways in which 'local' status could be cultivated. TW providers based in the town described instances where informal conversations with other providers had created opportunities to access resources. For example, a TW provider with an office base at the local authority described how she had been made aware of a community orchard through a conversation that took place when

passing a colleague's desk. Consequently, she had developed an apple-picking walk for her community walking project in conjunction with this provider. TW providers based outside of the town could circumvent their status as outsiders to some degree by "spending time" in the town which facilitated relations with other TW and non-TW providers (TW provider 02). One TW provider described how he had repeatedly visited local health centres, from where he hoped to get referrals to his project because, as he put it, providers can "see you and you can charm them" (TW provider 06). "Popping in" to community venues was considered useful because it was seen to be "important to … get your face known at places" (TW provider 03). Repeatedly visiting other local providers was associated with demonstrating a commitment to the town and its residents. One TW provider described how such visits helped him to convey this sense of commitment to other providers:

> When [local providers] realised we were doing a lot of groundwork and talking to a lot of different people, they could see we weren't going to be what they call a 'fly by night' and we were actually here for 3 years to deliver the programme. (TW provider 01).

8.5.3 Word-of-mouth endorsements

One of the ways in which some TW providers became more accepted among providers in the town was through word-of-mouth endorsements from providers considered to be 'local'. TW providers at an organisation with no history of working in the town asked a TW co-ordinator, based at the PCT, to arrange meetings for them with health practitioners in the town. One co-ordinator considered that these meetings provided legitimacy for TW providers and a "sort of reference … to actually get recognised as something that was kosher" (TW co-ordinator 01). These endorsements could start a process of discussion between providers, as one TW provider said, "It was certainly a door opener for us with the recommendation from the PCT" (TW provider 05).

TW providers considered it important that other providers understood and valued their work and this could be achieved through word-of-mouth endorsements. One TW co-ordinator said that because providers "don't know what [a new] organisation provides, they don't know anything about it so it takes, you know, quite a long time to … get that recognition sort of set up" (TW co-ordinator 01). One non-TW provider perceived that "it takes a few years before [a service] gets really embedded" in an

area (Non-TW provider 03). Describing the response of other local providers to her organisation, set up several years before the case study, one non-TW co-ordinator stated:

> It's taken us … years to get to the position … where people do trust us. I mean at first they didn't, at first it was like … nobody liked us, you know … because … we were like the new kids on the block … So it's taken a long time, I think, for the other organisations … to accept us and to trust us. (Non-TW co-ordinator 02)

Word-of-mouth endorsement from non-TW providers could therefore be effective for TW providers in developing collaborative working relationships. TW providers described how engaging one local school in a TW project could lead to the engagement of other school staff. She said, "Generally word got around about what we could offer and other teachers would then start to ring up and book in" (TW provider 08).

The influence of word-of-mouth processes can partly be explained by the perception among local providers that the VCS in the town was underdeveloped. With few established networks between VCS providers in the town prior to the TW initiative, word-of-mouth endorsements was a process through which 'local' VCS and statutory providers could gauge whether or not it would be helpful for them to work with the newly-developed TW projects. The sense of competition between providers in the town also influenced their sense of wariness and word-of-mouth endorsements enabled providers to judge the extent to which providers with new projects in the town might pose a threat to their own organisations.

8.6 Conclusions

The analysis presented in this chapter indicates that the capacity of providers to work together was constrained by their interdependency with other service providers, TW funders and other potential future funders. One of the consequences of the interweaving actions between these groups was the emergence of a sense of competition between providers, which had been unintended by TW co-ordinators. Tension between funded and non-funded providers during implementation was related to the competitive TW bidding process. The emphasis that TW providers placed on achieving targets in their work was influenced by co-ordinator

expectations and shaped a sense of competition between TW providers. A shared habitus between providers at the same organisation drew them together when working on TW projects. Shared dispositions and the fact that they were dependent on one another to bring in more funding (and keep their jobs) bound them to others in their organisation. Documentary analysis showed that little collaboration emerged between TW providers at different organisations.

Although documentary analysis showed that different TW providers worked with many of the same non-TW providers, their actions were rarely co-ordinated, and often served to threaten the chances of other TW organisations of working with these providers. For example, providers sought to cultivate a status as 'local' as a strategy to improve their own access to resources in the town and, in the case of TW providers, to achieve their targets. In order to do this, some TW providers contributed to the sense that some TW providers were 'outsiders'. The fact that VCS provision was not perceived to be well developed in the town appeared to heighten the sense of competition that TW providers felt towards each other. Analysis of quantitative data showed that TW provider collaborations with statutory providers were more common than collaborations with VCS providers. Few of the TW activities had been delivered within the town prior to the funding which meant that providers were keen to establish relations with 'local' non-TW providers in order to embed their activities. This strengthened their need to be viewed as 'local' and limited their willingness to collaborate with other TW providers new to the town. Analysis showed that more collaborative relations developed over time and that providers who were new to the area were able to earn their stripes as local and hence less threatening providers. The ways in which these relations influenced the development of TW activities and processes of change for residents are discussed in the following two chapters.

Chapter 9

Resident and service provider relations

9.1 Introduction

The aim of this chapter is to explore how relations between residents and TW providers developed over the course of the initiative in order to better understand processes of 'engagement'. Quantitative data are used in the first part of the chapter to describe the network of relations that developed. The chapter then moves on to explore the development of these relations in more detail with reference to resident and provider experiences. Building on the analysis in the previous three chapters a number of concepts were developed to explain the processes through which relations emerged.

9.2 Developing networks between residents and providers

The analysis in this section is based on data generated through TW monitoring arrangements. The number of residents participating in TW projects compared against the targets set gives some indication as to the extent to which co-ordinators' expectations were met. In light of the inconsistencies identified with regard to the way in which TW providers recorded participants as well as the confusion around the development of targets, this analysis should be viewed with caution. However, as discussed in the sections below, TW and non-TW providers and co-ordinators in the town paid attention to these data. In particular, TW providers anticipated that the findings generated through these data were taken at face value by the co-ordinators. Consequently, their inclusion here facilitates a better understanding of the ways in which these groups viewed project success. Table 9.1 shows the number of residents recorded as having participated in TW activities by December 2011, the planned end date for TW activities in Ellesmere Port. The data are broken down by TW project and compared against the targets set by TW co-ordinators and providers. The data have been ranked according to the percentage of targets achieved. The numbers in the table relate to 'direct participants' only, the terminology used by TW co-ordinators for residents who participated in a project activity "more than once" (NWPHO evaluation team, personal communication, November 2010, p. 4). Targets were not set at all projects for 'indirect participants',

who attended only once. As discussed in Chapter 7, participation targets were changed at several points during the initiative; the targets shown in the table reflect those most recently developed. The closest approximation has been used to report percentages as in all tables shown.

Table 9.1 Number of residents participating in TW by project up to December 2011

Project Name	Participant Target *	Actual Participants* n (%)*
Footprints	186	417 (224)
Pathways	47	85 (181)
Out and About	203	215 (106)
Grab a Bag	521	521 (100)
Get Involved, Get Active	518	424 (82)
Lots of Plots	200	135 (68)
Mental Health and Wellbeing	136	90 (66)
Workplace Wellbeing	139	70 (50)

* Source: December 2011 targets for Ellesmere Port projects. ** Source:(Groundwork North West, 2011).

Notwithstanding the aforementioned limitations, the data indicate that targets were exceeded in three of the projects. *Footprints*, for example, recorded more than twice as many participants as the target. Other projects were apparently less successful in reaching targets; the *Workplace Wellbeing* project, for example, recorded only half the number of expected residents. Other measures of success are discussed in the following chapter.

Demographic information relating to project participants provides some insight into the characteristics of residents participating in TW activities. This information is available from the monitoring database on which TW providers were initially required by co-ordinators to record participant details and attendance. There are, however, a number of limitations to using these data. As discussed in Chapter 7, the monitoring procedures set up were considered to be problematic by TW providers:

the database was introduced after delivery of activities had started; some participants declined to register their details and, in some instances, TW providers decided not to request them fearing it might jeopardise residents' trust. Furthermore, with the permission of TW co-ordinators, providers at two projects stopped using the database part-way through delivery and agreed to keep a record of both direct and indirect participants using their own methods. These providers routinely recorded participant information as part of their non-TW funded work within an organisation and used these processes to count participants. Consequently, data obtained from the monitoring database are incomplete and it is not possible to determine the extent to which registered participants were representative of all project participants.

As an indication of the accuracy of the data, the number of participants whose information was recorded on the database is shown in Table 9.2 as a percentage of the total number of project participants. Project participant figures in this instance reflect 'direct participant' numbers (those who attended once or more) as these residents were included in the database. The data show varied use of the database among TW providers at different projects. There was almost complete registration for participants in *Workplace Wellbeing* and very limited registration in *Mental Health and Wellbeing* and *Grab a Bag*.

Table 9.2 Numbers (percentage) of Target Wellbeing participants recorded on the registration database

Project name	Participants	Registered participants N (%)
Workplace Wellbeing	70	69 (99)
Pathways	92	85 (92)
Footprints	937	629 (67)
Get Involved, Get Active	1102	423 (38)
Out and About	640	110 (17)
Lots of Plots*	357	55 (15)
Grab a Bag	2639	182 (7)
Mental Health and Wellbeing*	90	6 (7)
All projects	**5927**	**1559 (26)**

*Discontinued use of the database part-way through the project

Despite these limitations, these data can be used to shed light on a sample of residents who participated in TW activities. All analysis is based on cumulative data up to July 2011 unless otherwise specified. GIS software was used to develop a picture of the geographical spread of the resident and provider network. Figures 9.1 and 9.2 show the postcode location of TW participants living in Ellesmere Port. The maps show that, over time, an increasing number of residents in the town had participated in TW activities, but that between July 2010 and 2011, a smaller proportion of participants were from the target areas of the initiative. By the end of July 2010, 895 residents were registered on the database, 518 (58%) of whom lived in the target areas. By the end of July 2011, 1559 residents were registered, 810 (52%) of whom came from target areas. Residents from all of the target wards participated in activities.

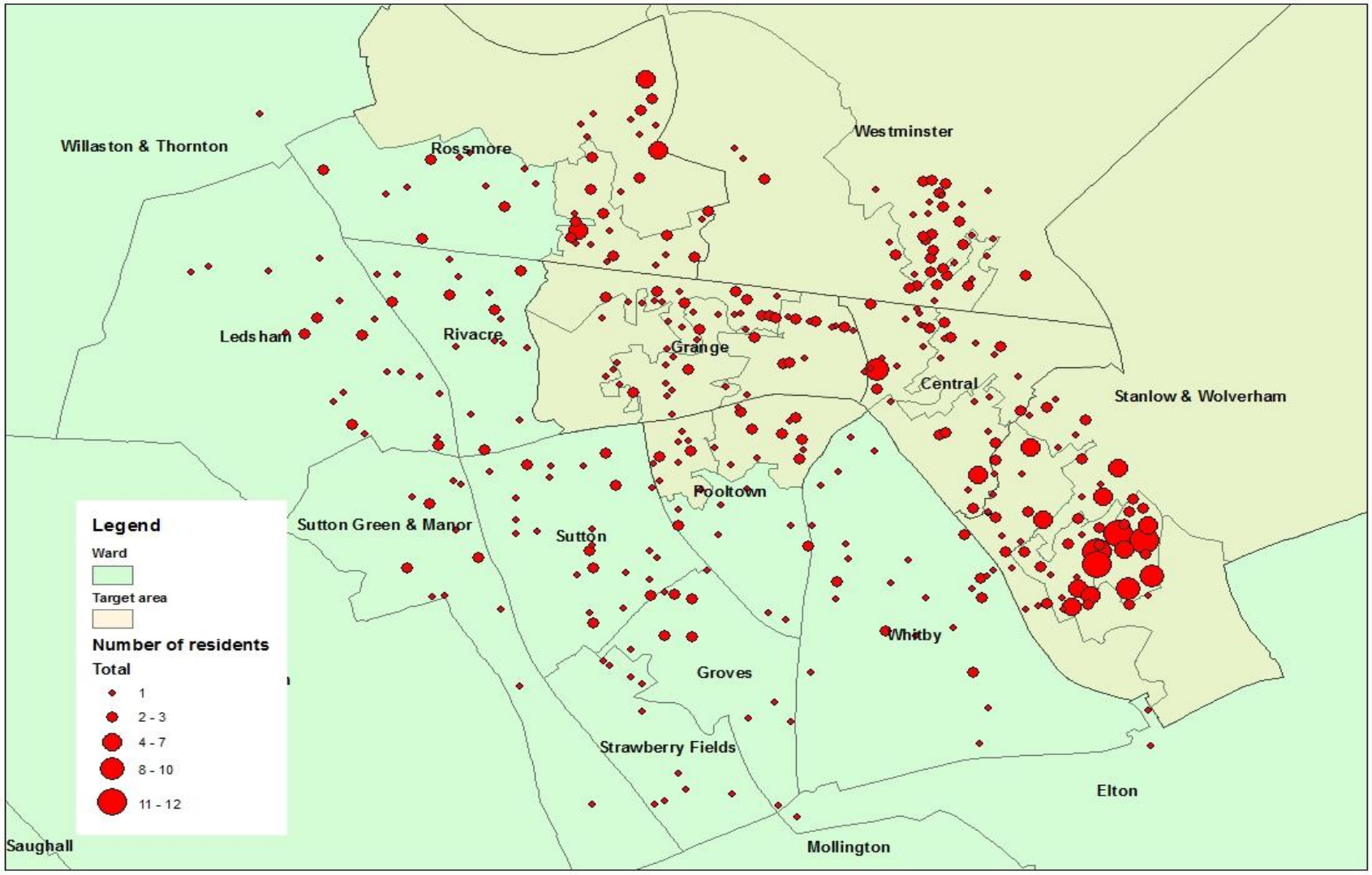


Figure 9.1 Target Wellbeing participants up to July 2010

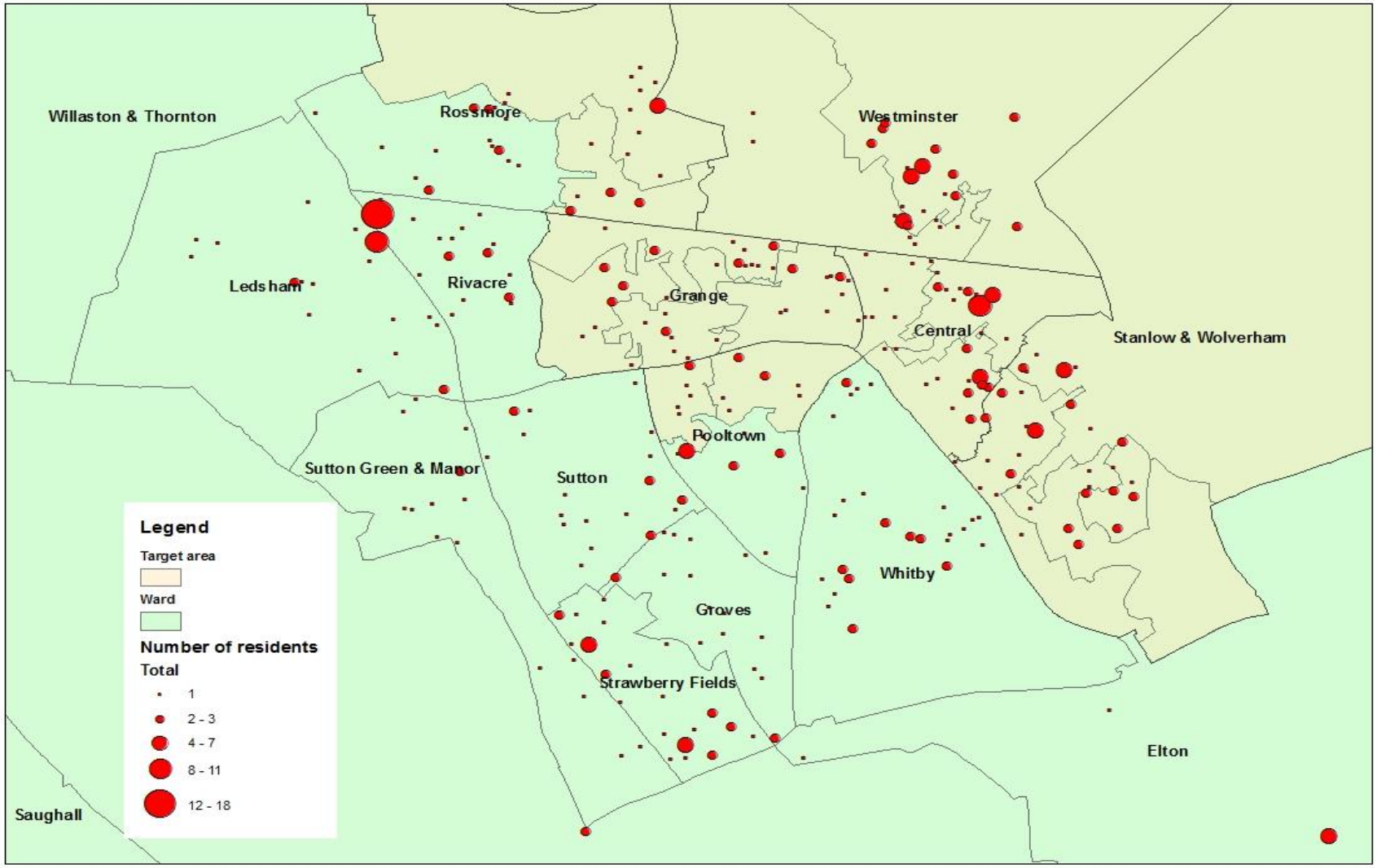


Figure 9.2 Target Wellbeing participants Jul 2010-Jul 2011

There were large differences across the TW projects in terms of the recruitment of residents from the target areas. Table 9.3 shows the number of registered participants living in the target postcode areas as a percentage of registered participants within each project by July 2011.

Table 9.3 TW participants living in target area

Project Name	Registered Participants	Living in Target Area n (%)
Grab a Bag	182	151 (83)
Mental Health and Wellbeing	6	5 (83)
Pathways	85	66 (78)
Out and About	110	77 (70)
Footprints	629	356 (57)
Lots of Plots*	55	30 (55)
Get Involved, Get Active	423	113 (27)
Workplace Wellbeing*	69	12 (17)
Total (all projects)	**1559**	**810 (52)**

*Discontinued use of the database part-way through the project.

At *Grab a Bag,* 83% of participants were from the target wards whereas at *Workplace Wellbeing* 17% of participants from the target wards. It is possible that the differences shown reflect variation in use of the database, given that *Grab a Bag* recorded only 7% of participants, and *Workplace Wellbeing* recorded 99% of participants. The variation across projects might reflect the fact that providers at different TW projects worked in different ways with residents. *Grab a Bag,* for example, was predominantly delivered within school playgrounds in a number of different target areas of the town. By contrast, *Workplace Wellbeing* predominantly delivered TW activities from locations in the centre of the town, where residents in some target wards were reluctant to spend time. However, *Pathways* activities were also delivered from the town centre but the percentage of participants at this project from the target areas was similar to that in *Grab a Bag*. Part of the explanation might therefore reflect differences in terms of the location of collaborating providers. As shown in the previous chapter, a large number of the providers with whom staff at *Workplace Wellbeing* worked, particularly for the referral of residents, were based outside of the target areas. The ways in which providers worked with residents are discussed in more detail in the sections below.

Analysis of participant postcode data also shows that residents from different parts of the town participated in different TW projects. For example, *Get Involved, Get Active* had particularly high numbers of residents from outside of the target areas. Given the limitations of the data, however, it is possible that residents living in these areas participated in these projects but were not recorded on the database. There was very little cross-over between projects among registered participants. Out of 1559 participants registered by July 2011 only 15 (1%) participated in more than one project and none participated in more than two. The only two projects to recruit the same residents were *Footprints* and *Get Involved, Get Active*, projects which both involved walking activities. These findings are unsurprising given that TW providers were reluctant to refer residents across projects. Differences in terms of delivery methods and venues could also provide part of the explanation for this, as discussed below.

Clusters of residents from small areas of the town were often registered at the same project. In some instances, the clustering of residents was explained by the fact that TW activities had been delivered within shared accommodation, such as sheltered housing in the Westminster ward. In other instances, analysis showed that a large number of people living in the same street had participated in activities at a particular project. Clusters of residents living on the border of Central and Grange wards had participated in the *Grab a Bag* project, for example, which was delivered in school playgrounds. It seems likely that residents with children attending the same school would live in the same local area. Projects that were delivered at a central location within the town however, also recruited clusters of residents from the same local areas. Analysis of postcodes for the *Pathways* project, for which activities were all delivered in Central Ward, showed that 4 residents living on the same street in different households had participated. The possibility that residents attending the same projects knew one another is explored in more detail in the sections below.

The age, sex and ethnic group of registered participants can be used to describe the residents who participated in TW activities. The age profile of TW participants is shown in Table 9.4.

Table 9.4 Age profile of residents participating in Target Wellbeing up to July 2011

Age (Yrs)	FP	GaB	GIGA	LOP	MHW	O&A	PW	WW	All projects
0--4	2	4	7	0	0	1	0	0	14 (1)
5-10	33	5	0	31	0	40	0	0	109 (7)
11-17	32	0	0	0	0	7	0	0	39 (2)
18--24	32	17	3	5	0	9	17	2	85 (7)
25--44	229	123	8	15	2	35	50	33	495 (32)
45--54	91	24	26	4	4	9	14	23	195 (13)
55-64	86	5	180	0	0	5	4	10	290 (18)
65+	124	4	199	0	0	4	0	1	332 (21)
Total	**629**	**182**	**423**	**55**	**6**	**110**	**85**	**69**	**1559**

Ninety per cent of registered TW participants were 18 years or older, however, this reflects inaccuracies in the data as analysis of qualitative data revealed that not all TW providers registered children on their database. Providers at the *Grab a Bag* project for example delivered several activities in schools but did not record the participants on the database. Reflecting the different target audiences, there were differences in the age profile of residents participating at each project. For example, work-related projects (*Workplace Wellbeing* and *Pathways*), were only attended by people aged over 18 years as was *Mental Health and Wellbeing,* designed for adults with mental health issues, although the majority of their work was with those age 25 years and older. *Get Involved, Get Active* was designed to target older residents. It is interesting to note that, despite this, some younger residents also participated.

The sex of TW participants is shown in Table 9.5 which shows that TW participants were predominantly female. *Lots of Plots* was the only TW project attended by more males than females. As Table 9.4 shows, the largest age group at this project was children aged 5-10 years.

Table 9.5 Sex of residents participating in Target Wellbeing up to July 2011

Sex	FP	GaB	GIGA	LOP	MHW	O&A	PW	WW	All projects
Male	122	19	88	36	2	33	13	12	325 (21)
Female	505	162	335	19	4	74	70	56	1225 (78)
Missing	2	1	0	0	0	3	2	1	9 (1)
Total	**629**	**182**	**423**	**55**	**6**	**110**	**85**	**69**	**1559**

The ethnic profile of TW participants is shown in Table 9.6. Reflecting the population of the town, participants were predominantly White.

Table 9.6 Ethnic profile of residents participating in Target Wellbeing up to July 2011

Ethnic group	All participants n (%)
White British	1407 (90.3)
White Irish	27 (1.7)
White Other	20 (1.3)
White & Black Caribbean	1 (0.1)
Asian British	6 (0.3)
Chinese	5 (0.3)
Other Asian	2 (0.1)
African	1 (0.1)
Black British	7 (0.5)
Other(please specify):	5 (0.3)
Missing	78 (5.0)
Total	**1559**

The frequency of contact between TW providers and residents as recorded on the database gives some indication of the way in which relations developed between participants who participated in a project activity.

Table 9.7 Frequency of contact between TW providers and registered participants

Project name	Once n (%)	2-3 times n (%)	4 or more times n (%)	Total no. participants
Footprints	521 (83)	73 (12)	35 (5)	629
Get Involved, Get Active	329 (78)	75 (17)	20 (5)	423
Grab a Bag	0 (0)	0 (0)	182 (100)	182
Lots of Plots	24 (43)	13 (24)	18 (33)	55
Mental Health and Wellbeing	2 (33)	2 (33)	2 (33)	6
Out and About	102 (93)	8 (7)	0 (0)	110
Pathways	67 (79)	2 (2)	16 (19)	85
Workplace Wellbeing	56 (81)	13 (19)	0 (0)	69
All projects	**1101 (71)**	**186 (12)**	**273 (17)**	**1559**

The majority of registered participants across all projects attended an activity only once, indicating that there was limited social contact between TW providers and the residents who participated in activities. There was variation across projects in terms of frequency of contact. Providers at the *Grab a Bag* project saw all registered participants four or more times. Participants in the *Mental Health and Wellbeing* project were equally likely to participate four or more times as they were once or twice although small figures make it particularly difficult to detect trends within this project. Providers at *Lots of Plots* often worked with residents more than once and this reflects the fact that they returned to schools to deliver a programme of sessions to children. The ways in which TW providers worked with residents are explored in more detail in the sections below.

This analysis presented so far provides only a limited view of developing relations, partly as a result of data collection limitations, but also as a result of defining participation in static terms. In monitoring terms, participation is defined as a dichotomous concept with all residents broadly defined as participating or not. The complexities of participation are obscured by focussing on the number of activities attended. Similarly, demographic information provides some indication of the context in which residents participating in TW activities lived, but, as the literature and earlier findings within this thesis suggest, the particularities of people' lives and

the way in which their relations with others develop are likely to have shaped experiences as well as the consequences of their participation.

A more detailed picture of participation is shown below, focussed on the processes through which resident and provider relations developed. A number of analytic concepts emerged from qualitative data generated through the case study which helped to explain these processes of engagement. The remainder of the material in this chapter is organised by these concepts.

9.3 Word-of-mouth information

The sharing of information by word-of-mouth emerged as a prominent social process through which residents gained information about TW providers and assessed the relevance of TW activities. The components that formed word-of-mouth information are described in more detail below.

9.3.1 Trusted sources

Word-of-mouth information was valuable to residents when it came from a trusted source. Information about services provided by friends tended to be valued by residents. Analysis of resident interview data revealed that participation in a TW activity was often preceded by a recommendation from a friend. The following quotation from a participant in a *Pathways* return-to-work course illustrates how the participation of one resident in an activity could influence that of her friends:

> Kim, she's my friend, she'd come from a work focus interview [at the Job Centre] and she [told them] she wanted to do something [in] caring … and they told her about the course and then she told me about it, so I went in [to the Job Centre] and made an appointment too to get on [the TW course]. (TW user 01).

Dense social networks between residents facilitated the process of sharing information by word-of-mouth. Describing how residents were made aware of her services, one non-TW provider said that "because … everyone in the Port knows each other, they all brought loads of people in" (Non-TW provider 06). A resident who volunteered at an advice centre in the town described situations where residents approached him personally for advice or contacted him following a personal recommendation. The language this resident uses in the quotation below suggests familiarity between the residents concerned:

> Somebody advised him to come to me. Someone that knew me and listened to him said, “Go and see Frank, he’ll sort you out” … Or people will stop me in a pub [to chat about a problem]. (Non-TW user 04).

Providers with whom residents had an established relationship could also form trusted sources of information. Interviews revealed instances where residents had been referred to TW activities from a non-TW provider whom they trusted. A resident who took part in a TW mental wellbeing project described how she had heard about it via a lone parent advisor at the Job Centre with whom she had a well-established relationship. She described her relationship with her advisor, Cheryl, and Cheryl’s relationship with the TW providers, in the following way: “This is how good she is, if … any part-time jobs come through, she posts them … [to me] ... And she knows Nathalie and Peter [within TW] anyway … but Cheryl’s lovely” (TW user 07). TW providers and co-ordinators perceived that trust was an important aspect of the referral process. One TW provider said that if people were referred to her service via their General Practitioner (GP) they were more likely to attend. She said, “We get very few who don’t turn up and I think it’s ’cause they trust their GPs and they trust the health service” (TW provider 05).

In this respect, TW providers who were new to working in Ellesmere Port were disadvantaged in the early stages of the initiative through having smaller networks of providers and residents. TW co-ordinators perceived that it took time for providers to “get bedded in” (TW co-ordinator 02) and to “build a profile” with residents (TW co-ordinator 04). A TW provider that was new to the area described the difficulty that providers without a trusted reputation might experience as a result of resident preference for word-of-mouth information. She said, “It’s a vicious circle isn’t it, ’cause you need [residents] to be going somewhere first before they can spread the word” (TW provider 03).

9.3.2 Is it relevant to me?

Word-of-mouth information was information that was relevant to residents. Receiving information about a service from a trusted source could help residents assess its relevance to them personally. One reason this influenced resident behaviour was because they trusted the judgement of the source of information. For example, A TW co-ordinator described how referral from someone whom residents respected could shape their belief that the referral was in their best interests:

> I think it is much, much more effective [than an advert in the paper] if somebody says to [a resident], "That's a really good idea, try this" … "Ooh my Health Visitor told me I should ring you", you know, "And I trust her." Or, "My doctor said this is a really good idea." (TW co-ordinator 01).

Personal referral to a service could persuade residents of its relevance to them. Residents who had taken part in *Pathways* were introduced in person to staff at the local Healthy Living Centre. One TW user said that previously she had "thought that the Healthy Living Centre was for single parents," that is, that they were "for [other] people, not me" (TW user 02).

Peer approval of services or activities also shaped resident assessment of their relevance. A resident who had participated in a mental wellbeing project said that she would not attend a physical activity project because she anticipated that "people would take the piss out of you … if you're going on a walk" (TW user 03). Activities were more likely to be considered acceptable when others with whom residents identified had attended an activity. For this reason, participation of friends in an activity could be an important catalyst for a resident's participation. The quotation below, from a resident in her 80s demonstrates how a friend's attendance at a non-TW community event, and her suggestion that she attend too, prompted her to reassess the relevance of an activity she had previously considered inappropriate:

> Somebody said, "Why don't you come to the dinners, why don't you come and have your dinner Flo, twice a week" … so I went on a Monday and a Friday.... [At first] I thought, "I can't go there." I thought, "I'm not old," you know. I put it down to the likes of [my] Aunt Mavis who would go there, not Flo. (TW user 09).

Resident reliance on word-of-mouth information can be better understood in relation to the historical context of service provider and resident relations within Ellesmere Port. As shown in Chapter 6, resident expectations about services were shaped by a sense of neglect and exclusion. Residents found it easier to access a service if they had received a personal recommendation that it was suitable for their needs. Local identities also influenced participation: if friends attended a service, residents were more likely to view that service as being suitable for people like them. Therefore, the way in which residents found out about a service shaped their response to it.

9.4 'Hard to reach'

There was an expectation among TW co-ordinators that TW providers would find it easier than others in the town to engage residents in activities. Notwithstanding this, there was a perception among TW providers that residents in Ellesmere Port were "hard to reach" (TW provider 13). This assessment of residents was expressed by TW providers new to the town and those who had worked there for many years. Other views that TW providers expressed challenged the idea that residents were hard to reach, as discussed later in the chapter. In order to understand how different views co-existed, the circumstances under which a view of residents as hard to reach was expressed are discussed below. The ways in which this view shaped resident and provider relations are also examined.

9.4.1 Individual resident characteristics

The term 'hard to reach' captures a view among providers that individual characteristics explained non-participation in TW activities. This was revealed in a number of different ways. First, the term was used by providers to describe resident attitudes towards health enhancing behaviours. Providers commonly voiced the opinion that Ellesmere Port residents were "stuck in a rut" (TW provider 03) or "set in their ways" (TW provider 04) with regard to diet and physical activity. In the quotation below a TW provider describes a lack of interest in healthy eating and exercise among Ellesmere Port residents:

> People don't really want to diet and they don't want to exercise do they? (Laughs) And … I would imagine that there's a lot of people in Ellesmere Port who don't do a lot of that so it's a very, kind of, difficult area to get change. (TW provider 04).

Another TW provider identified individual "inclination" as a key problem in terms of engaging residents in physical activity, suggesting that such a problem was "very hard to get over" when trying to build relations "'cause if somebody hasn't got an inclination to do anything, why would they go [to an activity]?" (TW provider 03).

Second, the term hard to reach reflected a view among providers that residents had low aspirations and that this made them unlikely to use services from which TW providers perceived they might benefit. Low aspirations were described in terms of a "lack of aspiration towards … education attainment" (TW co-ordinator 03); "no aspirations of getting work" (TW provider 14); and "low" career aspirations (non-TW

provider 03). TW providers and co-ordinators identified a divergence between their own views about living in Ellesmere Port and the views of residents. There was a tendency to see residents as tolerating and consequently perpetuating some of the difficult circumstances in their lives. The following quotation from a TW provider at a mental wellbeing project captures this well:

> Their personal lives are just in chaos, absolute chaos some of them, they come from very difficult relationships where they allow themselves to be in difficult relationships, again because they don't think that they're of any worth. (TW provider 13).

For providers and co-ordinators, these differences between resident and provider views partly explained resident attitudes towards services. One TW provider from a mental wellbeing project described how low aspirations made it more difficult for service providers to initiate contact with residents in Ellesmere Port:

> People seem less aspirational … [in terms of] what they want for themselves, so what they believe they can achieve … I think it makes getting the initial referrals in and people engaging initially much more difficult. (TW provider 13).

TW providers and co-ordinators firmly believed that involvement with TW activities would lead to improvement in the lives of residents; consequently, they interpreted non-participation as a signal that some residents did not aspire to improve their lives:

> You've got to understand that a lot of people might just not want to do anything. People might not want to improve their lives, they might actually be quite happy with the way they are. (TW co-ordinator 01).

The processes that shaped TW providers' belief in the value of their activities are examined below.

9.4.2 Emotional investment in participation

The term 'hard to reach' reflected TW providers' emotional investment in particular activities. TW providers produced activities that reflected their own interests and experience and consequently, they believed that the activities they designed were worthwhile. Describing how activities were designed within one of the physical activity projects, one TW provider said, "I just thought it would be nice to [do] and I do that anyway [elsewhere]" (TW provider 07). The apparent success of some of the TW activities in other areas shaped TW provider beliefs that activities were "good quality" (TW co-ordinator 01). Providers and co-ordinators were aware that some of

the activities that were being delivered as part of TW were also being delivered by other providers elsewhere. One TW co-ordinator perceived that 'success' in other areas meant that an activity was a "good" activity. Describing a new fitness phenomenon called 'Buggy Fit", she said:

> It's all over the country, everybody's doing it and we're providing it free in Ellesmere Port which probably nobody else is …. I mean in London, they pay about £8 a session for it … If people are asking for it in [a nearby Cheshire town] then it must be good, you know what I mean? (TW co-ordinator 01).

In some instances TW providers drew on their own experiences and inclinations rather than the point of view of residents to explain participation:

> I couldn't believe that, with *Grab a Bag*, that [recruitment] isn't going [well] … And I would love something like that … you know, I hate shopping so … I'd pay 6 months in advance and just go and pick up my bag at the end of the day. But people… I don't know. (TW provider 04).

Given their own belief that the activities they provided were interesting and valuable, TW providers found it difficult to account for the fact that some residents did not take them up.

The description of residents as hard to reach also reflected the emotional investment of TW providers in achieving targets. TW providers used the term 'hard-to-reach' to explain why they had not reached their targets. The reporting processes within the initiative had contributed to a sense of expectation among TW providers that they needed to account for low or no turn-out at some activities. Consequently, TW providers drew on the description of residents as 'hard to reach' to explain unmet targets. One TW provider said, "Ellesmere Port, it's hard to get your targets, you know, it really is a hard-to-reach area" (TW provider 08). The interdependence of TW providers with funders, potential funders and other potential service provider partners shaped the ways in which they made sense of resident participation. TW providers were constrained by their dependence on funders to provide a positive account of their own work, which could largely be achieved through portraying the behaviour of residents as problematic.

9.4.3 Removing barriers to reaching targets

This interpretation of resident participation shaped particular ways of working among TW providers. One of the processes it influenced was a focus on addressing

what TW providers perceived to be 'practical barriers' to resident participation. Changes were made to activity timings, venues and pricing in order to make it easier for some residents to attend. One TW provider described the changes made to physical activity sessions suggesting that if they were a practical possibility for residents, non-attendance could only be explained by individual inclination:

> We've focused on things in the day … but of course … some of them are caregivers … in the day, so some of them would be better off with an evening class … If you remove every other barrier [like transport] and people still aren't going, it must be because they don't want to or they don't feel the need to. (TW provider 03).

TW providers justified the changes made in terms of the need to meet resident recruitment targets. Describing activities at a mental wellbeing project, one co-ordinator said that providers there were changing what they delivered "to bump up the beneficiary numbers" (TW co-ordinator 01). One TW provider at the community walking project described how the need to focus on targets had encouraged her to make changes to activities which were benefiting only a small number of residents:

> You can't keep flogging the dead horse, if only one person is turning up for a walk, that's good for them but we've still got to meet targets, so we've got to look at other ways of attracting [residents]. (TW provider 08).

The perception that some residents were hard to reach persuaded TW providers that working with groups of residents who were more enthusiastic presented a viable solution to low recruitment numbers in the time that was available. One TW co-ordinator said that "the key [to a successful project was], actually getting in touch with people that are interested and getting them engaged" (TW co-ordinator 01), suggesting that residents who were harder to reach should be sacrificed. A provider at a physical activity project had recruited a large of number or residents from a social services centre attended by adults with disabilities. She perceived that when people were already engaged with a service, it was easier to get them to take part in TW activities:

> If they are already doing something, they are the ones that are coming on the walks …. it's easier, because … they already go [to something else]. It's still hard trying to get the people [by] knocking on their door, you don't get them sort of people, they have got to be already [using a service]. (TW provider 07).

TW providers identified a clash between the ethos of the initiative and this way of working which they defended with a need for pragmatism. Describing physical activity sessions that she had delivered with an existing community group, one TW

provider said, “[The project’s] not supposed to be just linked with the [community] centre …. But … that’s the most effective way that we’ve found of actually getting volunteers to come along” (TW provider 09). The quotation below from a TW co-ordinator illustrates that this approach was supported by co-ordinators:

> I think projects … are more likely to succeed [if] they have got a captive audience … projects that go into day care centres, as long as they can get the social services to sign up to that then they are sorted really, they’ve got their beneficiaries. (TW co-ordinator 01).

In addition to the benefit accrued in terms of meeting recruitment targets, TW providers identified an opportunity to promote their work to other residents by working with existing groups. This strategy also emerged out of understanding of residents as hard to reach as it built upon the idea that residents simply lacked motivation to participate. For example, one TW provider anticipated that the initial development of a community allotment site through the help of existing allotment groups would encourage others to attend because it removed some of the hard work.

TW providers worked in other ways to build relations with residents that reflected different views about residents’ experiences. These views were expressed under different circumstances which are described in more detail below.

9.5 Mediating the network

Mediating the network of relations explains the way in which provider and resident relations were influenced by the complex networks in which both groups were embedded. When removed from the context of discussion of targets, TW providers described the development of relations with residents as a complex process that reflected more than individual characteristics. Empathic understanding facilitated a more nuanced understanding of residents’ lives and reflected providers’ dispositions acquired over many years working with particular client groups. This understanding shaped ways of working with residents which differed from those described above. The circumstances under which emphatic understanding was developed and the associated consequences of this understanding are described below.

9.5.1 Empathic understanding

TW providers sought to understand how residents made sense of their experiences as well as their feelings. TW providers presented rich descriptions of residents' lives in order to convey the complexities of resident circumstances. A TW provider at a mental wellbeing project explained why the responsibilities of single mothers, targeted by the project, might mean that they had little time to consider their own wellbeing. The account presented of a single parent's typical day conveys a detailed understanding of residents' lives:

> [If] you're a single parent and you've got three kids, you got them to school at 9 o'clock and they're back at 4 o'clock, you're doing your housework during the day and doing your shopping during the day and doing the ironing during the day; doing everything that a single mother would do, where in the time of the day is that wellbeing? (TW provider 01).

Related to this, TW providers sought to describe how residents experiencing difficult circumstances might feel. Another TW provider at the same project described how "emotional [and] physical abuse" within personal relationships might affect residents' low sense of self-worth and subsequently, their confidence in seeking work. This provider perceived that working with residents to understand their family and personal experiences, past and present, was important as this revealed the "psycho-social issues" affecting residents' ability to work (TW provider 13). TW providers at a mental wellbeing project were also keen to emphasise that the particular focus on their work was on helping clients to deal with the impact that mental illness might have on their lives, including how they felt about themselves. During an interview, one TW provider said, "What we're interested in is the impact on the person's life that their [mental health] diagnosis has" (TW provider 14). The following quotation reveals how this provider sought to identify the particular emotional impact of these health problems on project users:

> So if you've been ill, if you've lost a lot of control over your life, if you're not doing very much, your self-esteem is naturally going to be very, very low and feelings of worthlessness can be involved in that. (TW provider 14).

Empathic understanding was developed over many years and reflected the professional and personal experiences which TW providers embodied. It was developed through experiences of working with particular health and social problems over many years. The shared organisational outlook which influenced organisational pull also shaped providers' understanding of residents' lives. TW

providers identified the specialist focus of their work as an advantage in developing an understanding about how they could help residents:

> It's always been clients at the centre [of our work] ... So whilst we've grown [as an organisation], and obviously we have a very mixed portfolio of funders now, we have so far … been able to stick to our own targets … to know what our clients can achieve, what our clients want to achieve and work that way. (TW provider 14).

There was a perception among users of this project that the particular focus on mental health within this organisation meant that providers there understood their needs. One user perceived that providers at the organisation understood some of the emotional difficulties that she might encounter returning to work with her mental health condition because that was the focus of their work:

> They have got a lot of understanding and empathy with working with people with mental health … whereas a lot of people really don't know what it's about. [The TW provider] is … for people … with mental health issues ... I suppose they have a better understanding … of the difficulties someone like myself can have. (TW user 10).

TW providers described how their own experiences influenced their understanding of those of residents. Shared experiences enabled providers to identify the constraints on residents' behaviour. One TW provider at a mental wellbeing project described how personal experience of unemployment facilitated an appreciation of the social constraints that unemployment sometimes perpetuated through residents' anticipation of what others might think:

> I didn't have a holiday for over 3 years when I was out of work, and that's why I make sure now that I'm back in work now, I get out socialising … [I'm] always saying getting back in work makes you feel healthier and fitter, and it makes you feel positive and you're not walking around with your head slumped thinking "I'm not working, I feel like vermin, everyone's looking at me thinking, "You haven't got a job"'. (TW provider 01).

Another TW provider at a mental wellbeing project described how her own experiences in school helped her to identify the influence of the learning environment on people' self-esteem:

> For a lot of kids that have done well in school it's … like, "Oh yeah, I'll be able to do A' Levels, I'll be able to go to university". But then there will be other kids with lower confidence who maybe have stalled a bit, but they're bright, it just isn't the environment that's working with them, who may not actually believe those things about themselves that they can move those steps forward, if that makes sense. I know; I was one of them (laughs). (TW provider 15).

Changes in TW providers' experiences sometimes challenged how they understood residents' participation. A provider at a physical activity project described how personal experience had prompted her to think differently about the perspectives of people living in Ellesmere Port. Having previously anticipated that developing appealing activities would be sufficient to engage people, the loss of her father had prompted her to reflect on her mother's motivation for social activities and consequently that of residents more generally. The quotation below demonstrates how the provider reassessed her previous perceptions of residents based on this personal experience:

> When my dad died, I thought my mum would be quite happy going out and doing things … but she has no inclination to go out and do anything and that's almost made me think again about people in Ellesmere Port. Cos I'm expecting all these people to come out to a class 'cause I think they'll enjoy it and it's the right level [of ability] for them and I know it's a really nice tutor … and you do everything to make this class as welcoming as possible and yet people still don't come. But now I think about my mum and I think, "Would my mum go?" (TW provider 03).

The use of peer mentors within one mental wellbeing project was a strategy used by TW providers to help them to develop empathic understanding of residents' experiences. One such mentor described how personal experiences gave her an appreciation of the difficulties experienced by her mentee when living in supported accommodation after a period of poor mental health:

> I might be able to say [to my mentee] something like, "Well yeah, I have, I do actually have [a mental health condition] myself" … "I've been through some stages of my life that have been very daunting and very hard". I mean, yeah, I did tell [my mentee] that I'd been in a similar place to where she was now so that I did appreciate what it was like. (TW participant 13).

Another provider at a mental wellbeing project described how insight from project volunteers, who were former project users, helped providers there to understand why some residents might fail to attend scheduled appointments with the project.

The volunteers were able to tell staff about their own experiences about non-attendance, as the provider describes below.

> So we might have [users who fail to attend] and we might think, "Oh they just don't want to engage, they're not interested". And yet one of our peer mentors might be able to say, "Well actually, you know what, I did that for a while, the reasons were…" (TW provider 13).

Understanding the complexity of residents' lives influenced the ways in which relations developed between residents and providers. These will now be explored, firstly in relation to empathic understanding more specifically.

9.5.2 The development of trust

Empathic understanding facilitated rapport between TW providers and residents; and, perhaps unsurprisingly, this was predominantly observed at mental wellbeing projects. Talking about a colleague on the project supporting people back into employment, one provider reported that "she's got a good understanding, a good one-to-one with [users]" (TW provider 01). Other TW providers perceived that offering this understanding was crucial to residents opening up about their feelings. One TW provider at a mental wellbeing project described how capacity to see things from a resident's point of view was crucial to encounters with residents:

> People … might [offload] to their friends or family, who will just probably wind them up a bit … [They have been waiting] for someone to understand really …. I think a lot of people come to us knowing the solution to their problem; they almost just want someone to validate it. (TW provider 05).

As well as influencing rapport, empathy was related to trust, which was described by residents as conveying a sense of "understanding" about their experiences (Project user 06); and "not … judging anyone by what they've done until you know what's behind it" (TW user 10). One resident described how TW providers understood what she was going through and said that, as a result of that, she trusted them enough to share her thoughts and feelings when she felt particularly unwell:

> Sometimes … I could, you know, speak to Peggy or Mary about … my illness … and how it's affecting me … because I've known them for a long time … and because I've got that trust with them and that understanding, I know I could put to them … what's going on in my head … whereas I might not be able to go and do that to somebody who doesn't know me as well. (TW user 10).

Other processes that were facilitated by an appreciation of the complexity of residents' lives are discussed below.

9.5.3 Outreach

Outreach is a process through which relations between providers and residents developed. It was a process that emerged out of providers' understanding about the complexities of residents' lives. Outreach was used by providers to convey their local status to residents. One TW provider described how he and a colleague had visited a local pub in order to speak to local people about their project. He disregarded warnings from other providers about potential 'trouble' in the pub in order to develop familiarity with local people and "get recognised" when spending time in the town. His personal experience of living in deprived areas influenced this attitude as the following quotation shows:

> Local people who work around here … said, "Oh don't go in The Knot for a drink; it's full of scallies. If they know you're not from the Port, you might be in trouble." So, we went in there on our first week … we go in rougher places than The Knot … we just had a word with the landlord there to tell him what we were doing. We've been in there a couple of times since and they see us here when we're promot[ing] the programme. (TW provider 01).

Within the same project, a resident was employed to speak to other local people to promote the project. The description she provided of her role suggested that it was loosely defined in order to allow her to take advantage of opportunities that arose in her day-to-day life, in the school playground or at a bus stop, for speaking to other residents who might be interested in the employment course. Her local status convinced the TW providers that "as a role model she's really powerful" (TW provider 13).

"Outreach" work was also defined as using "community venues" (TW provider 12), which also conveyed providers' status as local. Using these venues reflected what providers described as "working at that sort of grass roots level" (TW provider 13). Providers also associated working in this way with accessing word-of-mouth information networks. One TW co-ordinator described how using venues in the community made activities more accessible because they were approachable to residents:

> You'll get people who, there's no way they'd go to the ... leisure centre …. to engage with an aerobics group, but if you've got something that's running in your local community centre by somebody who is, not necessarily familiar, but approachable and engaging, you've got very local advertisements, you've got that whole word-of-mouth [approach], you know, involving people through their existing networks, through their existing support mechanisms, you've got a window to [engage them]" (TW co-ordinator 05).

The use of community venues reflected providers' understanding that being local was important to residents. Several TW providers referred to selecting a "neutral" project venue that was non-threatening to people from any of the target areas of the town (TW provider 05 and TW provider 01). The accessibility of venues also reflected resident's sense of entitlement to access it. One TW provider explained how the location of her organisation on a housing estate and its appearance as a home helped to convey a sense of entitlement to residents about using it:

> We're based here for a purpose, not just because, "Oh, we'll go and base ourselves here." The door's open, it's not locked. People can walk in. … It looks like a house. It's there for a purpose. We use community venues for that reason. (TW provider 13).

Residents living in Westminster were pleased that TW activities had been organised within their ward. One resident who had taken part in some of the walks organised through a physical activity project described her response to a flyer put through her letter box as it was within Westminster, or as she and others called, "the bottom end" of the town. Her feelings towards the area influenced her decision to take part in the activity, as the following quotation shows:

> [The flyer] said, "Come and enjoy the walk" or something nice, "Come and enjoy the walk, we're going on a nice walk, everybody meet at the Westminster [community centre], 10 o'clock". I thought, "Ooh, oh it would be going down the bottom end, oh, Flo was going on this". (TW user 09).

The influence of venue choice on participation is supported by the monitoring data which indicate that residents in some target areas were reluctant to attend venues in Central Ward. For those TW providers working predominantly in target wards, for example running most of their activities out of schools in the target areas (*Grab a Bag* and *Out and About*), recruitment from the target wards was higher than for other projects. TW providers who predominantly ran sessions from more central locations (*Health at Work, Footprints* and *Get Involved, Get Active*) tended to recruit higher numbers of residents from outside of the target areas. The *Pathways* project

was one exception to this; *Pathways* sessions were all delivered within Central ward but the projects predominantly recruited residents from the target areas. The outreach work in terms of promotion might provide part of the explanation for this. Postcode data from the *Mental Health and Wellbeing* project and *Lots of Plots* are more difficult to categorise given the low numbers recorded.

9.6 Conclusions

Reflecting the strength of local identities among residents and their diminished sense of influence over services, word of mouth played a significant role in resident decisions about participation in TW activities. This was visible in the clustering of participants in small geographical areas. Accessing information by word of mouth from people whom they trusted enabled residents to assess the relevance of TW services and the social acceptability of using them within the networks that were important to them. Providers sometimes formed trusted sources of information regarding other services but, partly as a result of limited collaboration between TW providers, participation in one TW project rarely facilitated access to information about another and few residents participated in more than one TW project.

TW providers held apparently contradictory views about resident participation which fostered different ways of working. An emotional investment in the participation of residents, which was shaped by both pressure to meet targets and TW providers' ingrained views about the value of particular activities, influenced a perception among providers that residents were hard to reach. This assessment focussed on the individual characteristics of residents and encouraged providers to work to develop individualised solutions to non-participation, working to address practical barriers to participation and foster motivation among residents. TW providers also held a view that residents' lives were complex, a view which was partly developed through capacity for empathic understanding. This view was invoked when discussing experiences of working with residents rather than discussing targets. The embodied experiences of TW providers working with particular groups, and the similarities between their own circumstances and those of residents in some instances, facilitated better understanding about the complexity of residents' lives. This understanding influenced providers to work in ways that developed resident trust; outreach was an important mechanism through which providers conveyed their local status to residents and created socially accessible environments for residents to attend.

Chapter 10

Processes of change among residents

10.1 Introduction

This chapter explores the consequences, intended and unintended, that arose from developing relations between residents and TW providers in order to identify processes of change among residents. In line with the theoretical underpinnings of the thesis, consequences are conceptualised as the social processes that emerged from the interweaving actions of residents, TW providers and TW co-ordinators. The chapter begins with an interrogation of quantitative data from the regional TW and bespoke project evaluations, which provide some insight into the extent to which anticipated 'outcomes' for residents emerged. Qualitative interview and observation data are used to examine these 'outcomes', and a number of unanticipated consequences, in more depth and to explain the ways in which they developed over time.

10.2 Measured outcomes

Quantitative data from the regional evaluation of TW were used by the NWPHO and Groundwork North West to measure the extent to which anticipated outcomes were observed among TW participants across the North West. The limitations of these data make it difficult to draw many conclusions about the consequences of participation for Ellesmere Port residents specifically, but they provide some context in which to interpret case study data.

In relation to 11 pre-defined outcomes specified by TW co-ordinators, the regional evaluation was designed to measure the extent of change against baseline data among residents following their involvement in TW activities. Baseline data were collected using 'welcome questionnaires' from a sample of residents during their first attendance at a TW activity. Respondents completed different questions based on the outcome themes of the project attended. Baseline measures relating to healthy eating assessed fruit and vegetable consumption, knowledge about healthy eating and food preparation skills. Questionnaires were used to assess physical activity frequency and intensity, and use of open spaces for physical activity. Mental wellbeing was measured using the Warwick-Edinburgh mental wellbeing scale and

a self-efficacy scale, measuring respondents' agreement with a set of statements about their wellbeing (such as, ""I will be able to achieve most of the goals that I have set for myself"). Measures were assessed at a second point in time using 'exit questionnaires' from a sample of residents following their participation in TW activities over an unspecified period. Change was not tracked at an individual level but rather was based on aggregated measures to report "relative improvements on average scores" (Timpson et al., 2011, p. 15). Exit questionnaires also asked participants to state whether they perceived participation in the project had helped them to:

- do your current job;
- find new employment;
- have better financial awareness;
- look after yourself physically;
- have better relationships with your family and friends;
- take care of your children;
- meet new people;
- or feel part of your community.

Aggregated change data from the evaluation sample was used in conjunction with participation data to calculate the number of residents for whom change might have taken place. The evaluation team required 30 entry and exit questionnaires to assess aggregated changes at a project level with statistical confidence (NWPHO evaluation team member, personal communication 30th March 2012). The number of exit and entry questionnaires returned for individual Ellesmere Port projects by March 2012 (the cut-off point for the most recent project-level analysis by the evaluation team) is shown in Table 10.1. Sufficient data to meet the evaluation requirements was collected at two projects, *Get Involved, Get Active*, and *Mental Health and Wellbeing.* At four of the projects, staff opted to complete a bespoke evaluation. Bespoke evaluations produced data that were not comparable to other projects. The only results made available from these evaluations were the number of residents achieving a positive outcome according to the providers' chosen measure.

The variation in the number of questionnaires returned partly reflects difficulties reported by TW providers in relation to using evaluation tools in different project environments. For example, in projects working towards mental health outcomes,

where TW providers typically spent more time with residents, participation in the evaluation was generally greater. In projects where providers worked with residents in an outdoor setting, such as *Lots of Plots*, *Out and About*, *Footprints* and *Grab a Bag*, the sample sizes were smaller or TW providers did not use them at all. Given the hostility that TW providers expressed towards the evaluation, it is also possible that these data reflect an unwillingness to support the evaluation process.

Table 10.1 Number of entry and exit questionnaires returned in the portfolio evaluation by Ellesmere Port project

Project name	Participants n	Welcome Questionnaires	Exit Questionnaires
Get Involved, Get Active	424	103	53
Mental Health and Wellbeing	90	61	58
Pathways	85	29	25
Grab a Bag	521	23	18
Footprints*	417	17	2
Lots of Plots*	135	0	0
Out and About*	215	0	0
Workplace Wellbeing*	70	0	0

*Did not participate in PHO evaluation

Across the North West TW portfolio as a whole the evaluation team were able to measure changes with more confidence. The number of questionnaires returned across the portfolio by November 2011 (the cut-off point for the most recent portfolio-level analysis by the evaluation team) is shown in Table 10.2 in relation to the main outcome themes measured.

Table 10.2 Welcome and exit questionnaires returned by outcome theme for the NW TW portfolio

Primary Theme	Welcome questionnaires	Exit questionnaires
Healthy Eating	219	185
Mental Wellbeing	772	346
Physical Activity	477	168

The analysis published by the NWPHO (Timpson, et al., 2011) indicated that the least improvement was seen in physical activity outcomes across the portfolio of projects. The evaluation team suggested that high scores at baseline assessment in relation to physical activity levels (as compared to the national average) might explain the limited improvement in physical activity outcomes. The team's suggestion that physical activity projects within TW had attracted people who were already physically active was, to some degree, supported by the findings from this study: TW providers at physical activity projects in Ellesmere Port said that people who were already active had participated in their projects. Within the *Get Involved, Get Active project,* the only Ellesmere Port physical activity project from where a sufficient number of questionnaires was returned for analysis, 31 more people achieved high or moderate levels of activity after participation in the project and 423 people had on average increased their walking time by 24 minutes.

Changes in healthy eating were small across the North West portfolio but there were increases in confidence in relation to food skills post-intervention and increases in the amount of fruit and vegetables consumed by the average TW participant (Timpson, et al., 2011). Notwithstanding the limitations of the data, analysis of evaluation data from Ellesmere Port projects participating in the NWPHO evaluation showed that residents across all of the town's TW projects had increased their fruit and vegetable consumption following involvement in TW. There are a number of possible explanations for this. Improving healthy eating was not a specified target for all of these projects but interview data revealed that providers discussed a wide range of wellbeing issues with their participants, including diet, which might have influenced changes. It is also possible that changes in one area of resident wellbeing were related to changes in others, so improved mental wellbeing scores for example, might have shaped resident perceptions about healthy eating.

Analysis of monitoring data indicated that few residents used more than one TW project, so it is unlikely that diet changes in non-food related projects was related to resident involvement in other food-related TW activities.

Most improvement was seen in relation to mental wellbeing outcomes across the North West portfolio. Aggregated scores for the portfolio as a whole showed a statistically significant increase in average resident wellbeing scores from 22.4 to 25.3 after involvement in TW (Timpson, et al., 2011). At the *Mental Health and Wellbeing* project, where sufficient questionnaires were returned for analysis, there were increases in wellbeing and self-efficacy scores among 78% of participants although the increases were not statistically significant.

While these data are indicative of changes to resident perceptions and behaviours, they create a picture of change as discrete, rather than processual. They therefore provide little indication as to how feelings, knowledge and behaviours might have changed over time and what might have influenced this. Attributing observed changes to resident involvement in TW activities is also problematic. It is possible that the consistently reported improvements in perceived availability of fruit and vegetables were related to other developments locally. For example, a new low-cost supermarket was opened in the town within the period in which TW projects were being delivered, which might have shaped resident perceptions about the availability of fruit and vegetables. The qualitative data presented below provide an opportunity to explore the ways in which changes among residents developed from the point of view of providers, co-ordinators and residents.

10.3 A shifting place in the network

One of the consequences of developing relations between residents and TW providers was that, for some residents, their sense of place in relation to a network of others changed. Through their involvement in TW activities, TW users extended their social networks and this influenced the way in which residents made sense of their circumstances and the possibilities open to them. The context in which these changes developed are described below.

10.3.1 Extending social networks

TW providers facilitated opportunities for residents to extend their social networks with other residents. Many TW activities were delivered in a group setting which provided opportunities for residents to spend time together. TW providers encouraged socialising among residents. One provider at a mental wellbeing project said, “We’re promoting the social, to get out and about” (TW provider 01). This provider described the way in which this was encouraged:

> At the end of the programme, what we encourage is that anybody who has completed the training and also done the placements as well we take them out for an end of course meal: A healthy meal in the local place in the Port area. (TW provider 01).

Participation in TW activities provided an opportunity for residents with small social networks that might be limited to the home to meet new people. Describing why she thought some residents with caring responsibilities enjoyed a community-led walk, one provider said, “I think their wives are at home ill and they just want a break” (TW provider 07). A resident in her 80s who cared for her two sons with long-term illnesses described how their ill health limited her opportunity to see other people. She explained that: “I can’t leave Glen, so I don’t go anywhere” (TW user 09). Previously, she had been reluctant to attend activities which kept her away from the home for long periods at a time. When a series of community walks had been organised in her local area she was keen to participate and described how she enjoyed the company of the walk leader. Describing a participant who had recently lost her husband, one TW provider perceived that a community walking activity “was just what she needed to get her out and get her meeting people again” (TW provider 03). Social contact with people outside of their immediate family had reduced for some participants following a period of poor mental health. Social interaction within TW projects for these residents was a novel experience in the current context of their lives. Describing why she thought participating in a course run at the *Mental Health and Wellbeing* project was helpful, one resident said it was “because I don’t really get out much so it helps me meet people” (TW user 04).

Social interaction at a TW project could also be one of the few forms of social interaction for residents who lacked confidence to create opportunities independently. Residents with long-term mental health problems and others who lacked confidence in social situations reported that they found it difficult to organise social activities outside of their involvement with a service. One TW provider at a mental wellbeing project described how a project user regularly attended social

activities but was reluctant to set up social meetings with his friends at the project independently of the project providers because, in the provider's view, he lacked confidence. She said, "[We were] really trying to encourage him to get in touch with a couple of people off the … project and do things independently … but he just wasn't too sure" (TW provider 15). Analysis of Interviews with residents with mental health problems revealed that independent social events could be daunting. One resident described how difficult she found social events and said that although she enjoyed the events organised by *Mental Health and Wellbeing* providers, she organised few social activities herself. She said, "I just do what I feel I can" (TW user 10).

Participation in an organised activity could be less daunting than setting up something independently. TW providers using work placements identified these as an opportunity for residents to engage with others in a supported environment. These providers perceived that the social environment of a placement was similar, but not identical, to a paid work environment where residents who had experienced long-term unemployment might experience more pressure to conform to social demands. One provider said that placements provided "a good way to introduce people … back into that sort of working environment … And get some sort of social interaction" (TW provider 14). This created an opportunity for residents to experience the banter, or "craic" that often occurs in a work place setting (TW provider 14).

10.3.2 Knowing 'how to be'

'Knowing how to be' reflects the way in which social activities facilitated by TW providers created an opportunity for residents with restricted networks to develop skills for mixing with new people. Residents and TW providers described a range of skills that were developed within the social setting of the project. One of these was the ability to communicate more effectively. For some residents, this took the form of identifying which types of conversations and what type of behaviour was socially acceptable in a new or neglected social setting. A non-TW provider who ran employment courses praised the way in which one of the TW courses enabled residents to "learn to interact again" (Non-TW provider 03). Similarly, describing how she had benefitted from a confidence course delivered at the *Mental Health and Wellbeing* project, one resident said, "It helps you like, you know when you have conversations, how to be and all that" (TW user 04). A TW provider at a mental

wellbeing project described the way in which she and other providers there sought to help residents with long-term mental health problems to develop communication skills:

> James has got a lot of scrap wood that he doesn't need [so] we were phoning the fire stations and seeing whether anyone needed wood for bonfire night … a couple of [project users], were doing the phone calls … so we were discussing what we were going to say on the phone, wrote a list out of the things to mention, and that sort of thing. (TW provider 15).

The small group environment of many of the activities was identified by providers and residents as "very important" (TW provider 13) in helping residents to develop confidence in speaking to new people. In the quotation below, a participant on an employment course described how the small group setting made her less reluctant to share her views:

> I found [the groups] hard, a lot of [people] they just get into it but I was a quiet one in the class. I did find it hard but I think I've got a bit more confidence towards the end … 'cause there wasn't that many of us, it was a small group and, like I said, the first couple of sessions I just sat back and … I liked it better as a small group to be honest. (TW user 01).

The opportunity to develop relations with other residents over a period of many weeks through weekly organised activities also helped residents to develop confidence in speaking to others. A participant on the *Mental Health and Wellbeing* courses described why he found it easier to communicate with people once he was more familiar with them:

> The [course] … that was all perfect … it was the same people who I met on [another course at the project]. [That was helpful] because I knew people so I could speak to them … it's hard to, um, hard to speak to people … because you don't know what to say to them because you might offend them or they might not like jokes or having a laugh or, because you don't know them. (TW user 05).

Learning 'how to be' was associated with being accepted, as described below.

10.3.3 Being accepted

One of the consequences of spending time with other residents and developing social skills was that TW participants felt a sense of social acceptance. This was sometimes achieved through the process of identifying shared experiences with other residents. Providers at a mental wellbeing project described how residents

developed friendships when they realised that they “share problems” (TW provider 13). One participant within the *Mental Health and Wellbeing* project suggested that her sense of isolation was alleviated by being made aware that other people experienced similar difficulties through discussions at the project:

> You sometimes think you’re so on your own and there’s nobody else out there who’s gone through [what you have] … So sometimes, if you feel isolated, … I think if you hear about other people and what they’ve gone through … it sometimes helps to know. (TW user 10).

Being accepted was also expressed as “fitting in” within new social situations (TW user 10). A provider at a mental wellbeing project described how the sense of belonging within a group could help residents to develop confidence:

> [The project is] helping people realise that they are valued members of the community and giving people back those aspirations … Because as you move forward in doing things and you start to feel you belong, your confidence starts to come back. (TW provider 17).

Spending time with other people and being accepted reduced the sense of isolation that some residents felt. One resident described how being with other people at a placement organised through the *Mental Health and Wellbeing* project had helped to bring her “back to reality” after a period of ill health and social isolation (TW user 04). The work that providers did to facilitate social interaction helped to make residents feel a sense of belonging. The following description of a social event at the *Mental Health and Wellbeing* project highlights the importance of the work of the providers in creating an environment in which residents felt comfortable being with others:

> [The TW providers] do … awards nights … they are really good because you get to meet a hell of a lot of other people … and you think, “Oh right, wow, that’s something I never thought … I’d ever do” … because … I’m not a good socialiser, I get so nervous and anxious about being with so many people but the ones that [are] put on [at the *Mental Health and Wellbeing* project] … have been very relaxed … and you felt part of it rather than being on the outside. (TW user 10).

Social acceptance was shown through the development of friendships. Through their involvement with TW activities, some residents formed friendships that developed outside of the project. A resident who had attended the *Mental Health and Wellbeing* project for several years described how she and other “friends” at the project would “go for a meal on a Tuesday” (TW user 08). A TW provider described how some of the participants on a TW course made arrangements to meet after the

course had finished: “The groups start off as strangers and end up as mates, exchanging phone numbers going out for a meal, Christmas dinners that sort of stuff” (TW provider 13).

These findings describe the circumstances under which change developed and what these kinds of changes meant to residents in terms of their sense of acceptance. Facilitating social contact between residents and enabling them to develop skills to communicate with others challenged resident perceptions about the way in which others might respond to them. This helped them to develop their networks in subtle ways – developing small numbers of new friends.

10.4 Changing expectations of services

The experiences described above, and the relationships that were developed with TW providers challenged some residents’ expectations of other providers in the town. The circumstances under which these changes developed are described below.

10.4.1 Developing receptivity to information

‘Developing receptivity to information’ reflects changes to the ways in which residents responded to information about services from TW providers. Gaining information about services through a trusted source was one of the ways residents made decisions about service use, as explored in Chapter 9. The development of relations between residents and TW providers extended the network of trusted sources that residents used. TW providers described the ways in which they used the relationships they had developed with residents to communicate information about other services in the town. A TW provider at a healthy eating project described how the time that she spent with residents enabled her to talk to them about other services in the town:

> We could always speak to parents in the playground about the various different things that were going on in Ellesmere Port and we would take flyers and leaflets and refer them to the various different classes that were happening in the healthy living centre and so they would know more widely about what’s happening in terms of exercise and other projects. (TW provider 10).

In circumstances where TW providers had developed trust, residents were more likely to be receptive to information shared about other services. The quotation below from a provider at a mental wellbeing project shows how the trust that providers developed with project users influenced their receptivity to information:

> Some of these people only begin to engage with you because you actually form that level of relationship with them. If it was a traditional, let's all sit round a desk and I'll stand at the front and I'll deliver a training session, they wouldn't even engage, they'd just walk off … So I think that because it seems to be very informal, it seems to be a chat … But actually, it's giving those messages but in a hidden way. (TW provider 13).

Residents who considered that TW activities had been relevant to their needs were also more likely to trust recommendations about other services from TW providers. A TW provider at an organisation based in the town described how the participation of residents in one activity at the organisation's base might lead to them asking for information about other local services:

> Once they've been once, they realise about all the other things we have going on and therefore they are more likely to then access us for that information and for that signposting. (TW provider 12).

Having empathic understanding, as described in Chapter 9, increased the likelihood of TW providers being able to identify services that might be particularly relevant to individual needs. Residents were more receptive to the information provided about these services that was tailored to their own concerns and therefore "useful" (TW 02). A non-TW provider who referred a large proportion of her service users to one of the mental health projects perceived these residents had engaged with work-based placements arranged by the TW project largely because it was relevant to their interests:

> [The TW providers] work hard in trying to find them a placement in an area that interests them because I think that's kind of a long way into ensuring that the client will utilise the placement if it's in an area that's, you know, of interest … I had a gentleman client who loved barges and [they] got him a placement at the boat museum. Somebody else that loved cats, so they got a placement at the cattery. (Non-TW provider 04).

Some residents responded to information differently partly as a result of involvement in TW. The following quotation from a resident who participated in the *Pathways* project shows how her expectations of services had changed. She said that one of the best parts of the course had been "[finding out] what there is out there really, we've had people coming in [to talk about] voluntary work, all the different things we

can do, you see I didn't know" (TW user 01). The resident said that she intended to get in contact with several service providers to whom she had been introduced via TW:

> Me and [my friend], we were getting in a rut, just sitting at home doing your house work, doing the shopping, you think that's it, but it's not, there's so many different things you can do if you go and ask someone. That's the thing isn't it, asking about it." (TW user 01).

The quotation suggests that her entrenched expectations about local opportunities had been disrupted by contact with TW providers. The social context in which information was provided also influenced the way in which residents responded to it. Some providers gave information about other services to residents in the small groups that were formed for delivering activities. The social acceptability of services was identified as important in resident decision making about service use and where residents heard about services within a group setting, they had often arranged to attend them together. Describing the way in which services were introduced to participants within group work at a mental wellbeing project, one provider said, "It gets people talking in a social way so a lot of them start to go to classes together" (TW provider 13). Resident comments suggested that decisions about attending services had sometimes been made collectively among TW participants. Describing her response to the presentation of information about the local Healthy Living Centre when participating in a TW employment course, one resident explained that she and her friend had decided then and there that "[they] are definitely going to go over there and see what there is" (TW user 01).

Residents' expectations of services were also influenced by social contact with other providers, facilitated by TW providers during their participation in a project. This is discussed below.

10.4.2 Developing experiential knowledge

Developing experiential knowledge reflects the ways in which residents' expectations of new services were shaped by taster experiences which TW providers organised. Some TW providers arranged face-to-face introductions between residents and other providers as part of their project work. In addition to facilitating the provision of information about other services, these introductions also provided an opportunity for social contact between residents and other providers.

Sometimes non-TW providers were invited to speak to residents within the setting of the TW project. For example, providers from the Citizens Advice Bureau and the Healthy Living Centre were invited to speak to participants on the *Pathways* project during the weekly sessions run as part of the *Pathways* course. Similarly, a TW provider at a physical activity project invited a provider from the local leisure centre to attend some of the activities that she ran, saying that "rather than just [giving residents] the information" about her services they could "put a name to a face" (TW provider 03). TW providers perceived that it was important that residents were introduced to "specific contacts" within services with whom TW providers had established relationships in order to facilitate residents' sense of ease within a new environment (TW provider 04). The importance of local status to TW providers was shown to influence which services providers referred their service users to; this analysis shows that TW providers anticipated that residents' encounters would be positive when referring to providers with whom they had established relationships. The place that TW providers occupied in the local figuration of service providers shaped their access to information and resources from other providers which in turn affected the information and introductions that they could provide to residents. This was demonstrated through the comments made by a provider at one of the physical activity projects who identified herself as an "outsider" (TW provider 03). She expressed frustration that the information she could provide to residents about other services was limited by the scope of her network. She said "It's just networking. And it's taken me a long time, I mean I came to the post about 15, 16 months ago and it's only now I think I can say, 'Yes, I do know somebody who can help you'" (TW provider 03).

Residents also gained experiential knowledge of services by spending time within the social and physical settings in which they were delivered. TW providers facilitated introductions to other services by taking residents to the service setting. TW providers running the *Pathways* course arranged visits to local training, advice and health centres for residents attending their course. TW providers at the *Mental Health and Wellbeing* project frequently accompanied project users on visits to local education and training centres. Providers perceived that accompanying clients to a service helped them to make the first step when starting something new. Accompanying to new services was described as particularly important for residents who lacked confidence in new surroundings. Analysis presented in Chapter 6 also indicated that residents' diminishing sense of *influence over services* could make it intimidating to access settings with which they were unfamiliar. A TW provider who

often referred residents to physical activity classes delivered by other providers said that she met residents at their first session in order to introduce them to the setting. She perceived that residents appreciated seeing a familiar face when first going to a new venue:

> I always make an effort to try and go to the first class where they register, just to say hello to people … because I think … it's quite intimidating going into a room with people you don't know … Just facilitating that transition into you know, a class and, "This is your tutor and here's the toilets", that sort of thing. And I think they appreciate that. (TW provider 03).

Accompanied visits were an important way in which residents developed confidence to access new services. At a mental wellbeing project, TW providers engaged volunteers to accompany residents accessing new services for the first time. TW providers considered public transport important for many of their clients' needs, and facilitating access to this public service by accompanying residents when using it was considered important by one TW provider:

> [A project user] wanted to go back to college … so she [needed] to … get on the bus and come down to Chester. She doesn't feel comfortable doing that but we will set up a volunteer to do that with her so… it was her confidence … in moving out of the area that she knows well … and not really knowing where she is going.(TW provider 14).

Residents said that accompanied visits had been a positive part of their TW experience. One resident who had been using the *Mental Health and Wellbeing* project for several years before it received TW funding described the role that his key worker at the project played in helping him to research further education options:

> [My key worker] always says "If you need anything, I'll come with you if you need, if you need to go anywhere, into any interviews or whatever, I can come with you". So she will probably come with me, she's going to come with me anyway to see, um, [the tutor] in the college … So I'm going to do me maths and English. (TW user 05).

Another resident who had used this project over several years said that the support that she had received from providers at the project to attend new services and activities gave her confidence so that she would be able to access other services in the future with their help:

> Whether it's doing voluntary work or going back to college … it can be daunting for anyone but if you've had some problems it can be … a lot, lot harder. If you've got that somebody … who can give you that initial support and maybe go with you on the first time … that is so beneficial. (TW user 10).

Facilitated visits to other services were also described by TW providers as a way of giving residents hands-on experience of the activities associated with using a service before they went alone. A non-TW provider who was introduced to residents on a TW employment course described the taster experience that she set up for residents who visited her training centre. Her comments indicate that these activities influenced residents to return to the service:

> What Peter (from TW) did, is bring them in and we'd do a little talk … and I'd put them on [an online course] as a preview and we talked to them about maths and English … and we did get a lot of people … who would sign up. (Non-TW provider 03).

One provider at a mental wellbeing project explained how providing residents with an opportunity to see what other providers did, could open up new opportunities for residents, who might otherwise not investigate options for addressing some of their concerns:

> Some people haven't got the walk-in mentality … to [approach services] … Sometimes you've got to lead somebody by the hand to actually do something … Some people haven't got the get up and go to actually say, "I need to go and sort [a particular problem] out" …. That's the idea of [getting other providers] involved [with the TW course] … it's a life skill. (TW provider 01).

Accompanied visits to service settings helped to persuade residents that they were eligible to use services. A provider at another mental wellbeing project described how accompanied visits involved providing residents with the practical skills and information they needed to identify and attend a new activity as well as the emotional help that was provided in helping the resident to feel comfortable in the new social environment of the activity:

> It's about that feeling that, you know, these facilities are not just there for somebody else because you're also building up self-worth a lot in mental health I think, just generally using public facilities. (TW provider 14).

10.5 Conclusions

Through the development of small changes to their social networks with other residents, TW participants developed a different sense of their place in a network of others. Social events that were facilitated by TW providers enabled residents to develop confidence in their social skills; residents described this as ‘knowing how to be’ in new social situations. The friendships that were formed between residents following their participation in TW gave residents a sense of being accepted among others, which encouraged them to try new activities in some circumstances.

The development of relations between TW providers and residents also extended the pool of trusted sources from whom residents could access information about services. As they developed more trust in TW providers, residents became more receptive to the information that these providers gave to them about other services. Meeting other service providers face-to-face and spending time in a service setting, sometime trialling a service before committing to attend independently, residents were able to assess the suitability of a service and some of their fears about service use were eased.

Chapter 11

Discussion

11.1 Introduction

In this chapter, the study's findings are discussed in relation to the research aims. The key aim of this research was to examine the social processes through which TW developed over time in order to assess the extent to which it had been a vehicle for social change. To address this aim, a "plausible account" of the processes through which TW developed in Ellesmere Port is presented (Charmaz, 2006, p. 132). The interpretive account pivots around three interrelated concepts, which reflect both the data that were generated and the figurational framework that guided the study. The findings are situated in relation to the existing literature on ABIs to demonstrate how this theoretical account refines and extends understanding in this field.

11.2 Power relations in provider figurations

The study shed light on the processes through which TW was commissioned and the ways in which relations between service providers in Ellesmere Port developed over time. The findings indicate that the commissioning process was important in establishing the pre-conditions for collaborative working in TW and for this reason, what emerged throughout the initiative could not be understood without reference to what took place in this early stage of the process. Conceptualising the introduction of TW into Ellesmere Port as a process that emerged out of dynamic social relations between large numbers of people helped to explain how the historical context of relations in the town shaped what took place. Established working relationships between a number of providers and co-ordinators gave these people more control over the commissioning process. These people did not have complete control over what developed however, because their actions were constrained by the requirements of the TW funders and by their own predispositions and expectations. The Thomas rule (de Swaan, 2001) suggests that expectations influence the consequences of collective action, and in the case of TW, co-ordinators' expectations about collaboration seemed to influence which organisations were commissioned to work together. TW co-ordinators knew the commissioned providers and their organisations and so they felt that they could anticipate how they

might work with others. Such expectations seemed to be shaped by the networks in which co-ordinators were, and had been, embedded. As might be expected, co-ordinators drew on existing knowledge and experiences in their decisions about which providers to commission. Explaining this in terms of co-ordinators' habitus helps to explain why co-ordinators might be drawn to work with providers with whom they have established relationships, locating their decisions in the context of their professional biographies.

By breaking down artificial barriers between the 'initiative' and the 'social context' in which it developed, the account of the commissioning process can more adequately capture the complexity of partnership processes than has hitherto been achieved. This way of viewing TW indicates that, as well as appreciating how interventions are "introduced … into an existing set of social relationships" (Pawson & Tilley, 1997, p. 70), consideration also needs to be given to the fact that interventions emerge out of existing relations. This provides a more adequate way of explaining connections between planned actions and their consequences as it emphasises the processual nature of social action.

Expectations among co-ordinators and providers reflected their emotional investment in particular consequences from their involvement in TW. There was a sense of anticipation among co-ordinators that by creating a new programme of projects in the town, providers at different organisations would be more able and willing to work together to improve service provision, particularly from the VCS and that this would lead to successful outcomes for residents. TW co-ordinators' ideas about collaboration were closely associated with their interest in demonstrating wide-scale change among residents to current and potential funders. Co-ordinators identified many benefits from collaborative working, which reflected their aspirations for the programme and, initially, they foresaw few potential problems or negative effects from collaboration. As such, these expectations can be seen to reflect the TW co-ordinators' interdependency with potential funders which influenced a greater degree of emotional involvement in their assessment of what was likely to happen. Elias (1978) argued that emotional involvement, created by one's position in a network of others, often obscures social processes to those involved. Co-ordinators' expectations proved to be unrealistic, indicating that their expectations were influenced by an emotional investment in particular outcomes, which prevented a more detached assessment of likely consequences. Given the policy mandates for

service provider partnerships, and the endorsement of collaboration in TW guidance documents more specifically, such expectations were perhaps to be anticipated.

Despite the fact that TW co-ordinators had more control over who was commissioned than providers in the town, they were unable to control the consequences of the commissioning process. The interweaving actions of providers and co-ordinators in the early stages of the initiative shaped the strategy that was developed in ways that the co-ordinators had not anticipated. The unequal balance of power between co-ordinators and providers in terms of control over TW funds, gave co-ordinators greater control over the way in which the strategy was developed in the early stages of the initiative. This power imbalance created some resentment among providers, however, which TW co-ordinators had not anticipated. Providers were able to subvert the process of strategy development at a later stage in the initiative by developing activities that better reflected their own priorities. 'Jumping through hoops' reflects the ways in which TW providers adhered to the requirements of funders and co-ordinators in the early stages of the initiative in order to create opportunities to deliver activities that reflected their own interests at a later stage. This suggests that although service co-ordinators appeared to have more influence over TW plans than service providers did in the early stages of TW, the involvement of large numbers of people in the initiative meant that no one group could control the way in which relations unfolded over time. Co-ordinators' position on the periphery of a large and complex network made it impossible for them to control the way in which relations between providers unfolded once funding was released. This suggests that power shifts within an ABI network, relative to the phase of development.

Organisational pull was a concept developed to explain processes that constrained partnership development and reflects the way in which TW providers at the same organisation were drawn to work together rather than with providers out-with their organisation. A shared habitus between providers at the same organisation drew them together when working on TW projects. Elias (1978, p. 15) argued that people "are directed to and linked to each other in diverse ways through their basic dispositions and inclinations", formed over many years through processes of socialisation. Working with the same group of people or in a particular field of professional practice over many years, providers at the same organisation had similar priorities in terms of what they thought was needed in deprived areas like Ellesmere Port. These findings resonate with those made in the field of teacher

education, where the term “occupational socialisation” has been coined to explain the way in which learning processes in a particular field of occupation come to shape perceptions (Lawson, 1983). Shared dispositions could be seen to bind TW providers together in this study such that they developed a sense of allegiance to the work of their organisation. Other work (Milbourne, 2009, p. 291) has led to the conclusion that "collaborative work often depends heavily on the commitment, dispositions and networks of people, and situated experiences" but has failed to explain why this might be the case. This research has shown how particular dispositions are formed through the social networks in which providers are, and have been embedded.

This process of socialisation into a particular profession or field seemed to constrain providers to work in ways that helped to protect their identities and future possibilities for employment. Providers at the same organisation had a greater dependence on one another for future work. They had an emotional investment in the continued success of their organisation since its continued existence (through the procurement of further funding) facilitated the maintenance of their professional identities. The process of competitive bidding, perhaps unsurprisingly, influenced a sense of competition between providers at different organisations in the town. Competition for funding between organisations within ABIs has been shown to undermine capacity for collaborative working (Carlisle, 2010; Milbourne, 2009). The findings from this research help to explain why this might be the case. The interweaving of co-ordinators’ actions with the actions of a range of other people connected to the town resulted in a number of consequences that the co-ordinators had not planned. A consequence of commissioning providers with whom they had established relationships was that co-ordinators, intentionally or not, limited the influence of some other providers in the process. An unintended consequence of this was that, having failed to be invited to bid for funding or having been rejected in their bid, these providers felt pushed out of the initiative and consequently, were less inclined to support the work of commissioned providers once delivery began.

Elias (1991) argued that no one person or group can control the outcome of a planned social process because they could not anticipate all of the ‘moves’ of other people with whom they are interdependent. These findings show how power balances within the network of co-ordinators and providers in the region influenced the way in which relations developed. Although non-TW providers apparently had

less power in relation to co-ordinators in terms of the initiative, they had the power to withhold their support from the TW providers.

The sense of competition between providers at different organisations seemed to be exacerbated by the evaluation processes set up. Co-ordinators sought to demonstrate change among residents in the town because they associated this with the ability to secure future funding. The development of targets reflected ingrained ways of working among co-ordinators; they were part of their everyday vocabulary and were part of the way in which they typically assessed the impact of an intervention or service. TW providers, however, had little or no influence over process of target development, which contributed to a sense of fear that the targets were unachievable. One of the unintended consequences of setting targets at an organisational level was that TW providers were persuaded that the number of residents recruited to activities at each organisation was vital to the funders, which limited TW providers' capacity to work towards other goals. The emphasis that TW providers placed on targets was also influenced by their past experiences of losing money for not reaching targets. This demonstrates that expectations about service delivery were produced over time and might not, therefore, be easily challenged through planned social action.

Another unintended consequence of the way in which the evaluation was set up was that measurements were open to manipulation by TW providers. The dependency of co-ordinators on providers' co-operation for the implementation of the evaluation meant that providers were able to subvert the process to some extent. The difficulties experienced by TW co-ordinators and the evaluation team in developing research methods, concepts and tools that were appropriate to a wide range of projects created a situation where providers were able to manipulate the process to construct a 'success story' that reflected more favourably on their organisation. TW providers failed to return new targets when requested and did not always make use of the evaluation tools, drawing instead on less rigorous methods of monitoring and evaluation. These findings resonate with those of Bloyce, Smith, Mead and Morris (2008) in relation to the way in which sports development officers manipulate centrally-developed targets for their own benefit.

These processes influenced a struggle for power among TW providers that was predominantly shaped by the status of providers as either local or outsiders. Local status was used as a tool for securing resources for one's organisation. TW and

non-TW providers and co-ordinators associated local status with a number of positive characteristics that facilitated collaboration with other providers. Having a history of working in the town, for example, made it more likely that providers understood each other's work. Cameron and Lloyd (2011) found that when providers understood and valued each other's work, they were more likely to work in partnership and Harris and Young (2010) found that providers who have displayed a sustained commitment to a cause within a local community are likely to have gained the trust of other providers. This research extends this analysis by showing that the development of trust can create included and excluded groups within ABI partnerships. Providers often attempted to cultivate a status as 'local' as a strategy to improve their access to resources in the town. This resonates with Elias and Scotson's (1965) finding that one's status as an 'established' member of a group can be used to exert considerable influence over resources that 'outsiders' might also value, but are less able to access.

Milbourne (2009, p. 287) showed how competition for funding between providers can exacerbate "fear of outsider [providers]" in community-based initiatives. This research builds on Milbourne's findings to show how the significance of outsider status in TW reflected power balances between providers. TW providers who considered their status as 'local' to be secure defined 'local' and 'outsider' status in dichotomous terms that served to reinforce their own apparently privileged position. This chimes with Elias and Scotson's (1965, p. 81) finding that competition for resources between people can influence a distorted representation of outsider groups by established groups through reporting a "minority of the worst" behaviour in local gossip circles. As in Elias and Scotson's (1965) study, people labelled as outsiders found it difficult to challenge this label, partly because they had fewer social ties in the figuration of service providers, at least in the early stages of TW, that might have facilitated an alternative image.

Sinclair (2008) has argued that partnership arrangements can make service provider relationships more complex, slowing down decision making processes which involve a large number of organisations. This research supports that argument and shows how provider decisions about what to deliver and who to work with in TW were influenced by the complex connections between a large number of people. Despite the relatively small geographical area in which TW was delivered and the relatively small number of organisations commissioned to deliver TW projects (as compared to other ABIs), the service provision figuration that emerged

out of the initiative was complex. New relationships were forged as part of the initiative, but this did not eradicate existing connections between providers. Past allegiances are unlikely to fade immediately with the introduction of a new initiative. The fact that VCS provision was not perceived to be well developed in the town appeared to heighten the sense of competition that TW providers felt towards each other. Few of the TW activities had been delivered within the town prior to the funding which meant that providers were keen to establish relations with 'local' non-TW providers in order to embed their activities. This strengthened their need to be viewed as 'local' and limited their willingness to collaborate with other TW providers new to the town. These findings indicate that co-ordinated working is always likely to be constrained by interdependencies between providers across organisations that precede ABI partnerships and are produced over many years.

It is important to avoid conceiving of networks of relations as static. The development of an initiative like TW, as with all social networks, is more adequately conceptualised as a process. Over time, Elias (1978, p. 131) argued, "fluctuating balances of power" within any figuration enable and constrain relationships that are developed therein. As such, it is important to understand that the position of providers as 'outsiders' could be modified, however slightly. Some TW providers were able to earn their stripes as 'local' providers over time. TW providers who were able to maintain frequent face-to-face contact with other providers, earn the endorsements of some 'local' providers and adapt their activities to fit in with them were more likely to earn 'local' status and develop stronger relations with others. This reveals that being viewed as 'local' was not fixed, but rather it was a consequence of one's changing social relation to others. These findings support the claims made by Bloyce and Murphy (2007) that established and outsiders might be most helpfully used to understand degrees of establishment in a community. A figurational view of power relations being constantly in flux is, therefore, key to an understanding of ABIs more generally, and the figuration around the TW-project quite specifically.

11.3 Mediating the Ellesmere Port figuration: provider-resident relations

In order to interrogate policy ideas about challenging social exclusion through ABIs, social change was examined in this thesis in terms of changing relations and power balances between targeted residents and people perceived to shape their experiences. The study sought to identify the ways in which relations between TW

providers and residents developed over time. Mediating the network of relations was a concept that was used to explain the way in which provider and resident relations were influenced by the complex figurations in which both groups were embedded. These networks are explained below. Elias (1994) argued that power balances in any network are shaped by the ways in which people are interdependent and that as the ways in which they are dependent on one another change, so too do the balances of power between them. Living on the periphery of a network is a concept that reflects the power balances between residents in Ellesmere Port and residents and service providers across the North West region. At the time of this case study, the “centre of gravity” (Elias, 1991, p. 51) in the North West network, in terms of greater influence over employment opportunities, lay in the more prosperous cities of Chester and Manchester. The process of LGR also changed the ways in which Ellesmere Port residents were interdependent with Cheshire residents: the organisation of services and the allocation of council funds across a wider network influenced a perception among residents that they had less influence over services in their town. Again, this was shaped by the sense that providers in Chester, where economic power was more concentrated in the newly formed borough, had more influence over decision making than Ellesmere Port service providers.

Living on the periphery of a network is a more adequate way of conceptualising the problems in deprived areas hitherto referred to as social exclusion as it reflects the way in which power relations influence a sense of exclusion. Contrary to the argument that relations between residents in deprived areas and the rest of society have been severed (Social Exclusion Unit, 2001), it is these relations that shape the experiences of residents in deprived areas. These relations are characterised by an imbalance of power that constrains the decision making power of residents in deprived areas, pushing them towards the periphery of particular decision-making networks. Chatterton and Bradley (2001) argue that macro and micro social processes influence exclusion from services. This might more helpfully be explained as constraints emerging from residents’ immersion in local, regional, national and global figurations, as changes that were experienced in Ellesmere Port reflected changes to the ways in which residents related to one another, to their regional neighbours and to the wider UK and global economy. This conceptualisation of the problem demonstrates that people are not ‘excluded’ from services or activities but rather ‘constrained’ by their connections with others. It suggests that people living in socio-economically deprived areas are connected to networks that contain economic resources, such as job opportunities, but that the balance of power within

those networks means that people in deprived areas have less control over such resources. This conceptualisation therefore challenges the ideas that social “factors” (Sanderson, 2000, p. 131) influence exclusion showing that, although not necessarily intentional, processes of exclusion are instigated and perpetuated by the interweaving actions of individual residents, service providers and employers and might therefore be amenable to change.

Ellesmere Port residents valued identities at a ward and sometimes even street level that were largely based on their relations with others living there. Local identities had value among residents because they facilitated a sense of belonging in an area that had lost other sources of prestige in the wake of industrial decline. In reality, residents might not have had the financial means to relocate, but the relatively static population also reflected an investment in relations based on a shared history in the area in the absence of other sources of identity, such as those based on employment. This resonates with the findings made by Mckenzie (2012, p. 459) that residents in “stigmatized” areas find value in living there through investment in “community and family social events.” The ways in which residents in Ellesmere Port developed a sense of self-worth reflected a struggle for power at a more local level. The concept ‘being local’ developed in this study conveys the way in which residents in Ellesmere Port developed localised identities that were partly based on influence over outsiders. Privileged understanding, which was used to convey local status, was based on the premise that outsiders did not appreciate the value of the area and hostility was sometimes shown towards people who lived outside of the area. Drawing on Elias and Scotson’s (1965) ideas about the role of established and outsider status in the development of power balances provides insight into the ways in which groups utilise resources at their disposal to gain power over other resources. Elias and Scotson showed how established status, among people who have lived in an area for a longer period than others, can be used to constrain people’ participation in particular networks in order to influence control over the benefits accrued through those networks. Cattell (2001) has argued that networks formed by residents in deprived areas are likely to be with friends and family, and others with similar characteristics. This research provides insight into the processes through which such networks are formed and shows that in deprived communities, dense social networks, in which ‘outsiders’ are forced into a peripheral position, provide a means of generating a sense of belonging among residents. This analysis therefore also offers a more adequate account of the ways in which communities within deprived areas are defined by internal power struggles, as well

as power struggles with their people in other areas of the country. These localised power struggles might also contribute to the processes that keep residents in deprived areas at the periphery of wider networks, in that outsiders are pushed towards the periphery of local networks.

Stephens (2007) has shown how residents' identification with their neighbourhood shifts in different contexts, which she attributes to calculations on the part of people about the potential value of social connections within particular social contexts. Residents in Ellesmere Port thought that they had little to gain from contact with services and invested in local relations with friends and family from which they perceived they could derive most benefit. These decisions were not entirely rational however; they were partly shaped by the balances of power in the networks that residents occupied, balances which were historically constituted. Elias's (1991) conceptualisation of habitus emphasises the ways in which interdependencies shape an individual's sense of self. Residents were constrained in the decisions that they made about relations with others by their dispositions and expectations, unconsciously formed over many years. Residents' expectations of services were partly formed by their peripheral place in the North West network. This can be understood with reference to what de Swaan (2001, p. 30) calls the Thomas rule, which states that "expectations affect what happens." Repeated disappointment over many years had shaped a sense among residents that they had limited decision making power in relation to services. Power balances at a local, regional and national level seemed to be related in this respect, in that power balances at the local level that influenced wider networks as described above, were also constrained by residents' positions in a regional and national network.

This analysis also sheds light on the relationship between what others have described as bridging and bonding social capital (Beaudoin, 2009; Poortinga, 2012; Putnam, 2000). Granovetter (1973, p. 1378) argued that "strong ties, breeding local cohesion, lead to overall fragmentation" suggesting that cohesive bonds between small groups can prohibit the development of links to people with different characteristics. This research supports the argument that access to bridging capital might be constrained by high levels of bonding capital and suggests that the particular figurations in which residents are embedded will constrain access to particular resources.

A discourse of neglect in relation to services emerged out of these processes which reflected both the recent experiences of different residents in the town and those of previous generations, who had experienced a similar sense of isolation in the early stages of the town's economic decline. The dense social networks that residents in Ellesmere Port inhabited might explain residents' mistrust of services. Research by Hothi et al. (2010) demonstrated how myth and rumours about services in particular areas impacted on residents' perceptions of services. This study made similar findings. One of the consequences of living on the periphery of a regional network and having a dense and limited social network was that word of mouth processes influenced the recycling of certain myths about services which were rarely, if ever, challenged. The findings indicated that, over time, the prevailing discourse of neglect became imprinted on the psyche of Ellesmere Port residents, shaping what Elias would refer to as "the habitus of a group" (Elias, 1991, p. 183). Residents' sense of place in relation to a network of others started to shape their expectations, such that new initiatives and services in the town were often greeted with mistrust by residents. The actions of service providers, even when shaped in direct response to feedback from residents, were interpreted by residents as a reassertion of the providers' power. Residents' interpretations of provider actions were based on what they expected to happen, on what their experience had taught them to expect. In this respect, residents' "taken for granted ways of perceiving, thinking and knowing" shaped their response to service providers (Paulle, et al., 2012, p. 71). Other research (Cox & Schmuecker, 2010, p. 45) has shown that people in socio-economically deprived areas have a "greater mistrust" of services. Living on the periphery of a network provides a way of understanding how this mistrust might develop. It captures the way in which interrelated determinants of health, such as unemployment, low income and social networks shape people's experiences of living in deprived areas and their participation in services. In addition to the practical issues that might make service use difficult, psychosocial processes also shape use of services. Identified determinants of health like 'unemployment' cannot, therefore, be thought of as descriptive 'background' variables to an initiative but as processes that shape relations between people and their view of themselves.

Residents' diminished sense of control over services could be seen to influence a perception that it was worthwhile to rely on personal endorsements of services. Word-of-mouth information was used by residents as a means for assessing the reliability and suitability of services. The dense, informal social networks that developed in small geographical areas in Ellesmere Port seemed to facilitate the

use of word-of-mouth information as such networks facilitated the development of trust. The process of friendship provided interactions in which ideas about relevance and appropriateness of certain activities were examined. These findings resonate with those of Archer, Hutchings and Ross (2003) who showed how information about higher education was valued by school pupils if it came from trusted sources as opposed to relative strangers. This research shows how people's place in a network shapes what kind of knowledge is valued and the ways in which such value is produced over long periods of time. In addition to these enabling effects, trusted sources, such as friends, also constrained participation in services. In some instances, anticipation that friends would disapprove influenced participation in services. Dense social networks might therefore to some extent limit the capacity of residents to access other forms of social capital, beyond the immediate network. Elias (1991, p. 52) argued that any decision an individual makes is made within the constraints of the structure of his or her sphere of activity and that each decision "allies him [sic] to some and alienates him from others". In this respect, the bonds of friendship made it difficult for residents to develop new networks without damaging existing bonds.

In different circumstances, providers conveyed different interpretations of residents' behaviour in relation to services, which was influenced by the place providers occupied in different figurations. First, providers expressed a view that residents were hard to reach. This interpretation of residents was based on an individualistic view of participation in services, which was expressed in relation to TW targets. TW providers identified individual characteristics as an explanation for why some residents did not participate in TW activities. These explanations for participation can be understood as providing an account of not reaching targets. Residents were usually described as hard to reach in the context of discussion about low turnout at particular activities and in relation to discussion about targets. In these instances, providers associated non-participation in services with low aspirations and indifference on the part of residents towards potentially health-enhancing behaviours. A perception of residents as hard to reach engendered particular ways of working among providers that focused on practical and individual psychological 'barriers' to resident participation. These findings can be better understood with reference to processes of medicalisation and individualisation of health which have influenced a propensity to "situate the problem of health and disease [and potential solutions to improve health] at the level of the individual" (Crawford, 1980, p. 365). Skrabanek (1994, pp. 16-17) described how these processes have influenced

perceptions of ill health and disease as “self-induced” problems caused by “irresponsible lifestyles.” The “lifestylism” (Skrabanek, 1994, p. 11) implicit in TW provider accounts in many ways reflects the fact that these providers were part of a wider network of practitioners whose livelihood depended on the promotion of health-enhancing behaviours. Providers seemed to draw on the discourse of lifestylism to explain low participation because this discourse provided an explanation for apparent failure to meet targets that was more acceptable to them.

Emotional involvement in participation can also explain providers’ views of residents as hard to reach. TW providers had an emotional involvement in the activities that they had developed, which tended to be shaped by a long-term commitment to health-enhancing activities. These associations can be better understood with reference to the Eliasian idea that emotional involvement inhibits adequate understanding about the influences on social phenomena (Elias, 1978). The views that TW providers expressed about residents in other circumstances, described below, suggest that providers held more nuanced views about the influences on participation but that emotional involvement influenced individualised explanations regarding participation in some circumstances, particularly when accounting for target achievement to TW co-ordinators.

In addition to the external constraints on providers’ behaviour, which emerged from their dependency on TW funders, providers also experienced internalised constraints on their behaviour that arose out of their place in a network of providers. The ways in which providers responded to and worked with residents can be explained by inclinations and dispositions which had been formed over many years. Providers conveyed empathic understanding towards the residents with whom they worked, which was informed by their history of working with a particular client group and/or personal experience of some of the problems experienced by residents. Providers drew on their experience of particular social issues, such as long-term unemployment, to try and understand the circumstances of the residents in Ellesmere Port with whom they sought to work. Elias described how previous experiences shape people’s dispositions towards new situations, conditioning expectations and social preferences. He argued that “people are directed to and linked to each other in diverse ways through their basic dispositions and inclinations” (Elias, 1978, p. 15). Empathic understanding reflects the way in which provider dispositions gave them particular insight into residents’ lives and an appreciation of the social constraints on resident behaviour, particularly in relation to

service use. In this respect, providers could be seen to be responding to the ways in which residents were constrained by their social networks.

These views contrasted with provider accounts of residents as hard to reach. The two apparently contradictory views can be explained by the different circumstances under which they were expressed. When providers described their relationships with residents participating in their services, they conveyed a more nuanced understanding of resident circumstances and the constraints that might have influenced their participation in TW activities. When discussing participation in terms of targets however, providers were more inclined to draw on individualised accounts of residents as hard to reach. This interpretive account explains provider views in terms of social constraints that operated simultaneously. Internalised dispositions operated in tandem with the constraints imposed by a providers' position in a network of providers and commissioners, shaping different views in different circumstances. Research into ABI participation has so far focussed on the practical work that providers do which might influence relations with residents (Anderson & Heritage, 1996; Harris & Young, 2010). This research develops understanding about the processes that inform providers' practice.

Empathic understanding can also be used to explain particular ways of working among providers such as outreach work. Providers understood that residents valued local information and that they relied on word-of-mouth information to make decisions about service use. Outreach helped providers to develop residents' trust by perhaps conveying local status to residents and creating socially accessible environments for activities. In this respect, providers were able to influence word-of-mouth processes to challenge residents' expectations of service providers. Over time, providers infiltrated the network in which resident decisions about service use were made. They were able to do this because they had developed an understanding about what residents valued and they knew how to perpetuate an image as 'local'. Providers seemed to understand that residents' decisions about participation were made in the context of their wider social experiences and worked hard to make sure that residents felt a sense of entitlement to use services.

This analysis shows that providers were constrained to work in ways that were shaped by resident actions. This demonstrates that recruiting residents to activities was a two-way process rather than something that was determined by provider actions and accepted passively by residents. Elias (1991) argued that all

relationships are characterised by power balances and that even the most disadvantaged people have power in relation to those who are seemingly more advantaged. Relationships between Ellesmere Port residents and service providers can be characterised in this way to explain how residents' networks influenced the ways in which providers worked. This is helpful because it encourages a view of 'engagement' as a complex process that is not solely shaped by the actions of providers. It helps to explain how relations between residents and providers developed rather than identifying practical barriers to resident participation which might differ in different settings.

11.4 Developing social capital: a shift in network position

Changes that developed for residents following their participation in TW activities can be described in terms of their changing place in relation to others in a network of interdependent people. Elias (1991) described how a person's perceived place in a network of others produces a particular habitus. Understanding changes experienced by residents in this study as a changing sense of place in a network reflects changes to the social context in which residents made sense of services and aspirations for the future. Potentially, these changes could lead to shifts in residents' habitus over time. Changes to resident networks were small and localised, and the data indicated that, throughout the period of the case study, many aspects of the social context in Ellesmere Port, such as the long-term issues of industrial decline, remained unchanged. Wider-reaching processes, such as industrial change, continued to shape residents' perceptions, as was shown through discussion about limited employment opportunities in the town. Residents also continued to draw on earlier experiences as a frame of reference for decisions which further limited opportunities for change and these experiences still influenced fear of social events. Despite this, small changes in resident networks were apparent, which had consequences for the ways in which residents related to each other and the way in which they related to service providers. The ways in which network changes influenced different resident experiences are explained below.

Through the development of small changes to their social networks, TW participants developed a different sense of their place in relation to other residents. TW activities provided an opportunity for residents to spend time with others in a supported social environment, the key aspect of which was that interaction was facilitated by providers. Facilitated social activities provided an opportunity for residents to

develop skills in communicating with others in ways that were experienced as socially acceptable, or as participants described it, learning 'how to be'. Learning 'how to be' was associated with being accepted in new situations, or situations from which residents had been absent for some time such as paid work environments. Participating in social activities in which they felt comfortable and accepted by others challenged residents' expectations about the way in which others might respond to them in new social situations. In some instances this influenced residents to initiate social activities, outside of organised services, when previously, they might not have done. Developing confidence in one's social skills could, however, take time and some residents were not comfortable initiating social contact outside of organised projects. Residents who participated in project activities for sustained periods of time, over a period of many months or even years, were also more likely to report changes to their social network. This demonstrates that learning 'how to be' in particular social situations was a process that took time and that residents' ideas about their capabilities were not easily challenged.

Harris and Young (2010) also found that community work among VCS providers could facilitate social contact between groups of people who would not normally spend time together. They found that spending time with others on a task led to greater trust between residents. This research made similar findings but is able to extend the analysis to show how the development of trust among a new network of people challenged resident perceptions about what they were able to do. This could be in relation to everyday tasks, such as making telephone calls, which are often taken for granted by other people. Conceptualising these changes as a shift in residents' network position shows how the context in which residents made decisions about relations with others was changed. Facilitated social activities created opportunities for social encounters that challenged residents' expectations. At TW events residents often experienced responses from others that they had not anticipated. Changes were most apparent among residents who had limited social contact with other residents outside of TW activities, perhaps due to a period of ill-health or unemployment. The reduced sense of isolation that these residents reported can be better understood in terms of a changing position in a network. As the discussion in the first part of this chapter shows, residents were not completely isolated: they were connected to and interdependent with others in complex ways. Facilitating changes to the ways in which residents related to other people, outside of their tightly formed family and friendship networks, encouraged a shift in their

thinking. The idea of a changed place in the network reflects the influence of social relations on people' sense of what they can achieve.

The idea of a changed network position also conveys the fact that changes might not be sustained. Elias (1994) described figurations as the temporary consequence of social relations, networks in a constant state of flux. The changes described here reflected changes in the way that residents related to others, which would continue to change over time. As the changes described here were experienced over relatively short periods in the context of residents' lives, they were likely to have a relatively minimal impact on residents' habitus. The analysis indicated that the longer that their sense of place in a network was sustained, the more likely residents were to change their social behaviour.

This analysis provides insight into the processes through which social capital might be developed through ABIs. There has been limited understanding thus far about the ways in which relations between residents have changed following an area-based intervention and the consequences that might emerge from the processes. There has been criticism that using social capital to understand what takes place in an ABI does not help to explain how social networks are constructed and thus how they might facilitate change (Magnani & Struffi, 2009). This study offers a theoretical explanation as to how new friendship ties are formed through participation in an ABI and how these ties might facilitate changed behaviour among residents. The study shows how the development of relations with service providers influenced the development of new friendship ties among residents. The development of new friendship ties moved residents from the periphery of a resident figuration towards a more central position within it. This social position gave them greater control over decisions that influenced their lives as shown by the ways in which new relations could influence residents to participate in new opportunities. An altered sense of their place in the network influenced some residents to participate in activities that they had previously considered beyond their capabilities, such as education, training or paid employment.

A changing sense of place in a network of others also helps to explain how residents developed what might be described as "linking social capital" (Szreter & Woolcock, 2004, p. 650), or benefits from their relations with people in positions of authority. Meaningful relationships between TW providers and residents challenged residents' expectations in relation to other providers. Cameron et al. (2009, p. 393)

also found that providers in a housing service acted as a “crucial link” between users and a range of other services from which they might benefit. This research provides insight into the processes through which relations with providers influenced access to other services. Drawing again on the concept of word-of-mouth processes, relationships between TW providers and residents increased the pool of trusted sources from which residents could access information about services. Residents become more receptive to information from these providers because they accepted them as part of their network. The social context in which information was provided to residents influenced the way in which they responded to it and gaining experiential knowledge of a service, by spending time in the service setting and with other providers, convinced residents that use of such services was consistent with their sense of self. By infiltrating resident networks, providers were able to change the context in which residents assessed whether using services was acceptable for people like them.

Others have described the development of linking capital as a process of “empowerment” (Stanton-Salazar, 2010, p. 1066). Stanton-Salazar describes how service providers might provide information, advocacy and advice in relation to networking in order to help residents to develop skills in accessing support from other services. This research helps to explain how residents are empowered through a changed place in relation to others. Developing relations with a TW provider could extend people’s networks, shifting them from the periphery and further towards the centre of a network. Their more centralised position in particular networks gave residents more scope for decision making, giving them greater power than they had previously. Preconceptions about services were challenged by new resident and provider relationships, which influenced the type of services that residents sought.

The following, final chapter of the thesis presents the conclusions that can be drawn from this interpretative account of the development of TW.

Chapter 12

Conclusions

12.1 Introduction

The purpose of this chapter is to present the conclusions that can be drawn on the basis of the interpretation of the findings. The public health issues raised in the first chapter of the thesis are revisited here in light of the interpretation of TW that has been presented. Specifically, the chapter deals with the problem of a lack of evidence to suggest that ABIs can improve health in deprived areas or address inequalities. The chapter also revisits policy assumptions about the potential for social change in deprived areas through service provider partnerships involving VCS providers and resident participation in health promotion activities. The implications of the findings in terms of public health policy and practice are considered. Finally, the particular strengths and limitations of the study are discussed in order to identify implications for future research in the field of health improvement and the field of health inequalities more specifically.

12.2 Theorising area-based initiatives

This study sought to examine the social processes through which TW developed over time. Studying an ABI processually presented a novel way to approach the problems associated with understanding these initiatives. The study has shown that a preoccupation with the measurement of 'outcomes' from public health interventions has limited the extent to which intervention processes are understood. Although attention has been paid in other studies to the issue of initiative 'implementation' in relation to ABIs, this approach has failed to adequately explain the emergence of unintended consequences from planned initiatives. By focussing on the relational aspects of a particular initiative, through a figurational lens, this study provides a way of explaining unintended consequences that have emerged out of ABIs as the result of interweaving actions between interdependent people. By explaining how change occurred within TW, and why unplanned outcomes emerged, the research has been able to assess the potential for social change within ABIs.

The attempt to provide a theoretical explanation for the development of ABIs in the public health field is important because it presents new ways of understanding and explaining well-documented empirical phenomena, including service provider partnerships and community engagement, drawing on the work of others who have sought to conceptualise communities of place in terms of social relations (Elias & Scotson, 1965; Macintyre, et al., 1993; Massey, 2005). In this respect, the thesis offers a more adequate conceptualisation of ABIs than has hitherto been achieved, which focuses on a number of interrelated social processes: the processes of partnership development; processes through which provider and resident relations might develop and the processes through which change might develop for residents. The theoretical perspective proposed in this thesis explains how these processes are interrelated.

The first major conclusion that can be drawn from the study is that co-ordinators and providers will be constrained in what they can deliver in ABIs by the social networks that they inhabit. The theory developed indicated that the social relations that constitute an initiative are established through the design and commissioning stages, when particular networks of power relations start to emerge. Studying the ways in which relations developed prospectively through ethnographic methods helped to identify the ways in which the early stages of the TW processes influenced the relationships that developed. Power balances between people involved in public health funding and delivery in the North West region shaped how the TW figuration came into being. This had important implications for understanding how relations between providers in the case study town developed over the course of the initiative. Early actions (such as the ways in which providers were commissioned) shaped the context for later events. Although power balances shifted throughout the course of the initiative, the shifts and patterns were shaped by what had gone before. This suggests that interventions do not have a discrete starting point and that, in contrast, they need to be understood as part of a continuous process, which emerges out of a complex web of social relations between large numbers of interdependent people. The predominant conceptualisation of ABIs as self-contained entities therefore needs revision. The alternative interpretation presented here enabled more adequate explanations for events occurring during the later stages of the initiative, as discussed below.

Theorising processes of joint working as interdependent relations explains why, in the context in which services are commissioned and performance managed, service

co-ordination is unlikely to be implemented as planned. In seeking to instigate joint working, TW co-ordinators underestimated the complexity of existing and emerging provider relations and perhaps over-estimated their own control over events. By uncovering some of the ways in which providers were interdependent with potential funders and other providers who could facilitate access to resources, the research suggests that co-ordinated working was constrained by the interweaving of many complex processes. The 'established-outsiders' concept has mainly been applied to the study of communities in terms of residents (May, 2004; Wouters & van Stolk, 1987) but the explanatory power of the concept in terms of understanding provider relations has been shown in this study. The concept informed the idea of 'being local' in this study, which helped to explain the ways in which power balances developed among providers, influencing access to resources through provider networks. The explanation developed suggests that partnership processes are not a failure of implementation, as some have argued, but a reflection of emerging social relations.

In the theory that was developed, an emphasis on figurations extending beyond the local area in which local non-TW providers and co-ordinators were embedded helped to account for the ways in which national policy and events shape the ways in which local service provider partnerships develop. TW did not become a vehicle for stimulating new VCS health promotion provision in the area as anticipated by co-ordinators partly because the actions of TW providers and co-ordinators were interwoven with those of a wide range of others. A range of developments at a national level, including a national financial crisis, a change of national government, an LGR and major restructuring of public health management from the NHS to local authorities influenced the development of new activities and policies locally. Alongside the development of TW, a plethora of other public health and health promotion developments emerged, while other related projects, such as those commissioned by the community sport network, disappeared due to lack of funding. The complexity of the figuration of providers and co-ordinators connected to the town was multiplied by these developments to the point that no one individual, including staff in senior public health roles, could understand the complexity of relations and developments that were emerging. To some extent, new developments pushed TW providers and co-ordinators to the periphery of service provision in Ellesmere Port and constrained their capacity to develop activities that might influence provision in the future, such as collaborative working across the VCS. This provides a more adequate way of conceptualising processes that have

hitherto been defined as separate entities, namely ‘an initiative’ and the ‘contextual factors’ that might influence its development.

The theory developed also provides a more adequate conceptualisation of resident ‘engagement’ processes than has hitherto been achieved, which takes into account the historical origins of relations between providers and residents within a particular geographical area. Using the idea of ‘provider’ or ‘group’ habitus provides a way of understanding provider practice in terms of working with residents. Providers made sense of residents’ TW participation based on their previous experiences of working with residents in professional settings. They also drew on their own personal experiences to try and understand participation from the point of view of residents. Empathising in this way enabled providers to identify the complex web of people and events influencing resident participation in TW activities. However, empathic understanding was not the only influence on provider actions. Conceptualising providers’ practice as constrained by their relations with other providers, commissioners and funders, provided a way of explaining why they sometimes held apparently contradictory beliefs about residents, such as the tensions between a view of residents as hard to reach and empathic understanding. At times when providers felt under pressure to explain their inability to meet resident participation targets, they assessed resident actions in a different light. This can be explained in terms of providers’ dependence on funders and their emotional involvement in demonstrating ‘success’ in terms set out by commissioners (participation targets). The case study approach facilitated examination of the context in which providers developed ideas about working with residents and helped to show how different provider practices emerged in different settings.

This challenges the notion that provider characteristics can be explained in static terms and suggests that expectations about the role of the VCS in encouraging resident participation in health improvement activities needs more careful consideration. This study has shown that VCS providers are subject to the same constraints experienced by statutory and private sector providers when working with residents. Understanding the circumstances that shape the work of VCS providers is likely to produce more realistic expectations about the ways in which they might work with residents.

Resident ‘engagement’ in TW activities could also be more fully understood as an emergent process that was by no means discrete or linear. Residents’ participation

in activities reflected the complexity of their wider lives. The history of relations between residents and providers in the town influenced the expectations that residents had of service providers. Their contact with TW providers was viewed through the lens of these expectations. The importance of local knowledge sometimes enabled myths about services to survive in the town unchallenged. Understanding resident relations with providers in these terms helped to explain how relations developed through disruption to long-term processes. When providers were able to develop a reputation as 'local' and to demonstrate empathic understanding, residents' preconceptions could be challenged. This indicates that resident relations with service providers need to be understood in the historical context of the region.

Finally, the study sought to identify the consequences that emerge for residents who participated in an ABI and the ways in which these related to the relations developed between residents and providers. Theorising outcomes in terms of consequences that emerge from interweaving processes can help to explain changes as part of an on-going process. For example, the development of relations between providers and residents reflected a shift in the context in which residents made decisions about service use and this facilitated access to different opportunities for residents. This helps to explain the processes through which social capital might be produced through developing relations between providers and residents. It was difficult to assess the extent to which such changes would be sustained, suggesting that the term 'outcomes' was inaccurate. Given that relations between groups of providers and residents are always in a constant state of flux, it was difficult to discern the 'order' of events that led to change, indicating that linear models of cause and effect in public health interventions would benefit from reconceptualisation. The sociological interpretation of change processes among residents presented here indicated that social life is complex and that relations between different groups of providers and residents are constantly in flux. The study was able to explain links between processes and consequences and suggests that thinking in terms of propitious circumstances or the preconditions that enable certain developments is more helpful. This has important consequences for the ways in which public health interventions are evaluated and our understanding of their potential value in influencing change in areas of high socioeconomic deprivation. These issues are discussed in the final two sections below.

12.3 Implications for policy and practice

Better understanding about the ways in which residents and providers make sense of their circumstances can inform how policy makers and commissioners can work with them to bring about change. This study drew on the experiences of these groups to develop a theory about ABI development. An important implication of this study is that collaborative working is difficult because of the figurations in which ABI service providers are already immersed. One of the unintended consequences of the initiative was the emergence of a sense of competition between TW providers and non-TW providers. This study indicates that the conditions in which services are commissioned will establish the pre-conditions for collaborative working. Tension between funded and non-funded providers during implementation of TW projects was related to the competitive TW bidding process, a common antecedent to UK ABIs. The bidding process created tensions between providers who were funded and those who were unsuccessful in their funding bids. That 'unsuccessful' providers were expected to work to support 'successful' providers proved to be unrealistic. Minimising competition between service providers through changes to commissioning processes is likely to establish more conducive preconditions for co-ordinated working.

These findings suggest that VCS providers face similar constraints to their counterparts in the statutory and private sector in terms of their ability to co-operate with other providers in their local area. VCS providers are immersed in complex webs of interdependency that limit their capacity to work towards inter-organisation goals defined at an area level. Particularly given the current funding pressures on VCS organisations, it would be wrong to assume that VSC providers will be less competitive than their counterparts in other sectors when working towards localised public health action.

Despite the fact that research has revealed the potentially negative impact of competition on inter-organisation collaboration before, the fact remains that service co-ordinators are unable to control the unintended consequences that often emerge from competitive processes. Even though the co-ordinators of such initiatives hold positions of relative power in relation to funding, they are still heavily reliant on those whom they eventually choose to carry out the projects. Commissioners will never be able to exercise complete control over the way in which providers work together as power is never held exclusively by any group, and this was clearly the case in this study. It is important to appreciate that several other social processes are likely to

influence the ability of any one group to co-ordinate service delivery even in a relatively small geographical area.

This has important implications in terms of understanding what is likely to emerge from continued UK Government interest in localised working. Seeking to co-ordinate the actions of large numbers of providers within small geographical areas, for example through Health and Wellbeing boards, is unlikely to produce the 'outcomes' intended by area leaders. The emphasis on local action, with limited reference to the wider figurations in which it is embedded (at regional, national and international scales), is likely to limit the capacity for change and subsequent health improvement.

Joint working tended to be viewed as a technical or managerial issue in this initiative, as shown by the complex reporting and monitoring arrangements that were set up. Less emphasis was placed on supporting social relations. Although monitoring and evaluation processes are important, it was clear that the development of targets at the level of an individual organisation were not conducive to collaboration between providers at different organisations. This raises questions about the ways in which joint working might be better encouraged and nurtured. Local status, which represented commitment to the area and legitimacy to some providers, facilitated the development of relations between particular providers. To some extent, the concept 'being local' reflects a power struggle between providers for resources that could facilitate the development of activities but it did nevertheless facilitate collaboration. The influence of this status could be nurtured among co-ordinators to develop more supportive conditions for collaboration.

The study indicates that a more adequate conceptualisation of targeted ABI communities is required at policy level, which will inform the ways in which practitioners work. The concept of social exclusion, which has been closely associated with ABIs, has diverted attention away from the processes that constrain the actions and opportunities of people living in targeted areas. The discourse of social exclusion, perpetuated at a policy level, influenced the ways in which providers worked with residents in some instances. Coupled with the pressure providers felt to meet recruitment targets, this influenced a view of residents in the initiative area as 'hard to reach.' This view constrained the ways in which providers worked with residents and focussed their attention on practical 'barriers' that they

perceived prevented resident participation. The policy discourse of social exclusion is therefore potentially damaging to the ways in which providers work with residents.

Provider actions were also mediated by their habitus, which influenced an appreciation of residents' circumstances. Drawing on the knowledge and understanding they had gained over many years, providers were able to recognise, to some degree, the wider processes that constrained resident participation. Encouraging providers to work in ways that build on their own experiences might encourage the development of service delivery that reflects empathic understanding. Taking an historical, developmental view of Ellesmere Port indicated that the particular history of an area is likely to shape how local initiatives unfold. More nuanced understanding about the conditions in 'deprived areas' could provide insight into the processes that might constrain resident participation in services. The theoretical insights developed in this thesis indicate that a more receptive context for change might be developed if providers are aware of the nuances that shape resident perceptions of services in local areas.

This indicates that the current policy emphasis on VCS providers and voluntary action more generally as a route to health improvement in local communities has limitations. Even though this study showed that VCS providers often have skills and experiences that might inform their work with residents, their immersion in figurations that extend beyond the VCS means that they are constrained in their capacity to work with residents in ways that might be reflected in other sectors. VCS providers contribute to the discourse that presents some residents as hard to reach. Recognising some of the constraints on VCS provider actions, might encourage commissioners and policy makers to develop more realistic expectations about the ways in which they can work with residents.

In terms of assessing the potential for social change among residents within ABIs, the theory developed in this thesis indicates that change is most likely to occur through changes to the context in which people make sense of their experiences. Processes influenced through TW shifted the pattern of social relations for some residents such that residents were linked to others in new ways. From this, certain opportunities emerged and skills were developed. The development of particular types of services locally and the actions of those who worked in them seemed to shift the resident figuration in Ellesmere Port towards the development of more formal interdependencies. This might be thought of as social capital of the form that

can lead to certain positive advantages. This form of capital, which helps people to make 'vertical' connections to people of different social strata, including those beyond the 'community,' potentially offers access to wider networks and the potential to leverage a broader range of resources. Szreter and Woolcock (2004) described this as linking capital.

The changes described above usually took some time to develop, in many cases changes emerged over the course of several years. Marmot (2010) has called for less short-term projects and more mainstreaming of services to better address the determinants of health. Based on these findings, this study supports that recommendation. These findings indicate that there is a need for more realistic expectations among policy makers about what can be achieved through short-term ABIs. Although small changes were revealed through resident and provider accounts, their sustainability was not fully examined in this study. The findings indicated that other processes influenced by degrees the actions of residents, which might threaten the sustainability of any changes. This has implications for what might be expected from an ABI. If research into ABI processes considers interdependencies between ‘local’ people and people in neighbouring areas, for example, the constraints on decisions made within that locality can be more realistically imagined. Intervening in one local figuration is unlikely to influence what happens elsewhere as other processes, such as resident relations with people in neighbouring areas, will continue to constrain their actions towards services.

This raises some real concerns about the value of ABIs as a tool for addressing inequalities in health. It shows that poorer health and social outcomes among people in deprived areas are unlikely to be improved through action targeted on these areas in isolation. The initiative examined in this thesis was a vehicle for small, localised and potentially short-term social change.

12.4 Strengths and limitations of the study: implications for future research

The processual approach to studying provider relations enabled the research to examine the ways in which relations changed over time. The extended period spent in the field was a particular strength of the study and created an opportunity to examine changes in the power dynamics between providers and co-ordinators. This was facilitated by the use of a range of different data generation methods.

Examining the connections between providers through documentary data, interviews and observations provided opportunities to examine connections between people in the figuration. Documenting change over time, partly through quantitative methods, meant that links between events could be made. However, problems with the recording of quantitative data collected at Ellesmere Port projects through the NWPHO monitoring and evaluation processes limited the scope for using this data to describe changes over time. The limitations of the quantitative monitoring data within this study emphasised the difficulty of measuring change and linking it to initiative activity. Exploring the monitoring process as a social process indicated that data recording problems are likely to persist in evaluation of social interventions, given the constraints experienced by those charged with recording them. This indicates that pre- and post-intervention data are unlikely to produce insight into processes of change within social interventions.

The study might have benefitted from interviewing a larger number of service providers a second time to more fully explore changes over time. Exploring the early stages of the bid process in more detail might also have provided further insight into the ways in which ABIs develop out of emerging relations. In particular, examining the ways in which co-ordinators came together in the very early stages of bid development might have shed more light on different dimensions of power between co-ordinators and providers. When examining any process, however, it is always difficult to identify an appropriate starting point for the study, given the connections with what has taken place before. Similarly, extending the length of time spent in the field would have facilitated more detailed examination of the ways in which policies were changed in the area in the months and years after TW funding ceased. Local plans and initiatives started during the fieldwork were still unfolding after fieldwork ceased. Examining whether and how TW co-ordinators and providers might have become involved in these over time might have provided more insight into longer-term processes emerging out of the actions of TW staff. This is always likely to be the case when exploring social phenomena in their real life context as new developments will always occur after the completion of a project. Future research could examine what happens when an ABI comes to an ‘end,’ exploring whether and how learning from the initiative informs new service developments and initiatives in an area.

There were a number of limitations to the sample that was drawn. Few non-TW users were recruited to the study. Examining the experiences of residents who had

less contact with services might have uncovered different processes. In addition, the quality of the data generated with some residents was limited. Interviewing people who were not used to interacting with someone they did not know, such as some people who had been unemployed for long periods and/or had enduring mental health problems, created some difficulties. It was particularly difficult to develop rapport in an interview setting and it might have been more productive if more time had been spent in the field engaged in participant observation to develop relationships with potential participants before interviews took place. Exploring different methods of data generation, informed by the preferences of participants, might have produced more valid data. This indicates that there might be a role for action research in this area.

The case study design used in this research was coherent with the theoretical ideas that underpinned the research and enabled connections between people and events to be explored. Events and participants could be sampled according to emerging lines of enquiry that were informed by figurational concepts. Working in a grounded theory way, emerging explanations about the data were tested out by generating data that might support or contradict the theory being developed. Looking at longer term processes and national and local processes, as case studies permit, allowed 'we' and 'they' perspectives to be combined. In this respect, small-scale figurations could be situated within the context of the wider figurations in which they develop. A limitation of the grounded theory approach is that it fragments the narratives of participants. Exploring the biographies of individual participants might have shed further light on experiences outside of their professional roles that shaped providers' practice. For example, examining the ways in which political beliefs might have influenced providers' decisions to work in particular fields and for particular organisations could provide more insight into the processes driving their work with residents. Future work could explore the ways in which VCS providers work with residents drawing on this perspective.

Employing a grounded theory approach prevented uncritical use of the figurational concepts and reduced the risk of imposing interpretations on the data, which improved the validity of the explanations developed (Charmaz, 2006).. The data collection and analysis techniques specified by a grounded theory approach (such as those advocated by Charmaz, 2006) facilitated the blending of involvement and detachment to which figurational sociologists aspire in the study of social

phenomena. This study indicates that grounded theory is a useful approach for the application of figurational ideas in the pursuit of knowledge.

The blending of broader sociological concepts with grounded theory indicates that social theory can play an important role in understanding public health interventions through empirical investigation. Drawing on ideas from sociological theory, the research was able to demonstrate the ways in which public health action is constrained by the interdependency of human beings. Bringing sociological concepts to bear in the study of planned public health action holds a great deal of promise for understanding how change might be influenced.

To conclude, the study provided a more valid account of social change in ABIs than has hitherto been developed, which focussed on the developmental and relational nature of such initiatives. By conceptualising ABIs as a social process, the study developed a more meaningful explanation of the ways in which ABI co-ordinators and providers might influence changes in deprived areas. The study showed that more realistic expectations about co-ordination between providers might be needed given the complexity of service provider networks, even in relatively confined geographical areas. By conceptualising the changes that took place among residents as small shifts in the power dynamics within resident and provider figurations, the study showed that there are limits to what can be developed through ABIs given that conditions in deprived areas are shaped by complex networks that extend far beyond the local area.

References

Acheson, D. (1998). *Independent inquiry into inequalities in health (the Acheson Report)*. London: The Stationary Office.

Ainscow, M., Dyson, A., Goldrick, S., Kerr, K., & Miles, S. (2008). *Equity in education: Responding to context*. Manchester: Centre for Equity in Education, University of Manchester.

Alcock, P., Brannelly, T., & Ross, L. (2004). *Formality or flexibility? Voluntary sector contracting in social care and health*. University of Birmingham.

Allmendinger, P., & Tewdwr-Jones, M. (1997). Post-Thatcherite urban planning and politics: a Major change? *International Journal of Urban and Regional Research, 21*, 100-116.

Anderson, B. (2006). *Imagined communities: Reflections on the origin and spread of nationalism*. New York: Verso.

Anderson, Y., & Heritage, Z. (1996). The voluntary setting and its contribution to health promotion. In A. Scriven & J. Orme (Eds.), *Health promotion: Professional perspectives* (pp. 179-186). London: Macmillan.

Andrews, R., & Entwistle, T. (2010). Does cross-sectoral partnership deliver? An empirical exploration of public service effectiveness, efficiency, and equity. *Journal of Public Administration Research and Theory, 20*, 679–701.

Angrosino, M. (2007). *Doing ethnographic observational research*. London: Sage.

Anning, A., Stuart, J., Nicholls, M., Goldthorpe, J., & Morley, A. (2007). *Understanding Variations in Effectiveness amongst Sure Start Local Programmes*. London: The Stationary Office.

Ansari, W. E., & Weiss, E. S. (2006). Quality of research on community partnerships: Developing the evidence base. *Health Education Research, 21*, 175-180.

Archer, L., Hutchings, M., & Ross, A. (2003). *Higher Education and social class: issues of exclusion and inclusion*. London: Routledge Falmer.

Aspinall, P. J., Hudson, D. M., & Lawton, R. (1982). *Ellesmere Port: The making of an industrial borough*: Ellesmere Port and Neston Borough Council.

Association of Public Health Observatories and Department of Health. (2008). *Health Profile 2008 Ellesmere Port and Neston*. Retrieved 10/01/2009, from www.healthprofiles.info

Association of Public Health Observatories and Department of Health. (2009). *Health profile 2009: Cheshire West and Chester [Electronic version]*. Retrieved September 23, 2010, from www.healthprofiles.info

Asthana, S., Richardson, S., & Halliday, J. (2002). Partnership working in public policy provision: A framework for evaluation. *Social Policy and Administration, 36*, 780-795.

Atkinson, R. (2000). Narratives of policy: The construction of urban problems and urban policy in the official discourse of British government 1968-1998. *Critical Social Policy, 20*, 211-232.

Atkinson, S., Holloway, E., Rose, J., & Wholey, N. (2003). *Community research in Ellesmere Port & Neston Borough Council area*. London: The Boundary Committee for England.

Baggott, R. (2000). *Public health policy and politics*. Basingstoke: Palgrave.

Baker, S. E., & Edwards, R. (2012). *Review paper: How many qualitative interviews is enough? Expert voices and early career reflections on sampling and cases in qualitative research*. Retrieved October 30, 2012, from http://eprints.ncrm.ac.uk/2273/4/how_many_interviews.pdf

Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Pettigrew, M. (2009). Tackling the wider social determinants of health. *Journal of Epidemiology and Community Health*. Retrieved from http://jech.bmj.com/cgi/content/abstract/jech.2008.082743v1

Barnes, J., & Cheng, H. (2006). Do parental neighbourhood perceptions contribute to child behaviour problems? A study of disadvantaged children. *Vulnerable Children and Youth Studies, 1*, 2-14.

Barnes, M., Matka, E., & Sullivan, H. (2003). Evidence, understanding and complexity: Evaluation in non-linear systems. *Evaluation, 9*, 265-284.

Barr, A. (2005). *Outcome based community development practice – how did we get here and does it matter?* Paper presented at the Scottish Community Development Alliance Conference, Glasgow.

Bartlett, D., & Payne, S. (1997). Grounded theory: Its basis, rationale and procedures. In G. McKenzie, J. Powell & R. Usher (Eds.), *Understanding social research: Perspectives on methodology and practice*. London: The Falmer Press.

Bartley, M. (2004). *Health inequality: An introduction to theories, concepts and methods.* Cambridge: Polity Press.

Batley, R., & Edwards, J. (1974). The Urban Programme: A report on some programme funded projects. *British Journal of Social Work, 4*, 305-331.

Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M., & Sullivan, H. (2005). Promoting Social Change: The experience of Health Action Zones in England. *Journal of Social Policy, 34*, 427-445.

Bauman, Z. (1979). The phenomenon of Norbert Elias. *Sociology, 13*, 117-125.

Bazeley, P. (2007). *Qualitative data analysis with NVivo*. London: Sage.

BBC News. (June 4, 2001). *Events: Newsnight*. Retrieved March 16, 2012, from http://news.bbc.co.uk/1/hi/events/newsnight/1372220.stm

Beacon Dodsworth. (2009a). *Beacon Dodsworth's geodemographic classification: Understanding people by where they live*. Retrieved May 12, 2011, from http://www.beacon-dodsworth.co.uk/uploads/files/p2-brochure.pdf

Beacon Dodsworth. (2009b). *Demographic data: P2, People & Places geodemographic people classification.* Retrieved May 12, 2011, from http://www.beacon-dodsworth.co.uk/site/products/demographic-data/

Beatty, C., Foden, M., Lawless, P., & Wilson, I. (2008). *New Deal for Communities: A synthesis of new programme wide evidence: 2006-07*. Wetherby: Department for Communities and Local Government

Beatty, C., Foden, M., Lawless, P., & Wilson, I. (2010). Area-based regeneration partnerships and the role of central government: The new Deal for Communities Programme in England. *Policy & Politics, 38*, 235-251.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics*. Oxford: Oxford University Press.

Beaudoin, C. E. (2009). Bonding and bridging neighborliness: An individual-level study in the context of health. *Social Science & Medicine, 68*, 2129-2136.

Benzeval, M. (2003). *National evaluation of Health Action Zones: The final report of the tackling inequalities in health module*. Retrieved July 25, 2011, from http://www.sphsu.mrc.ac.uk/benzeval-m.-the-final-report-of-the-tackling-inequalities-in-health-module.pdf

Berkeley, D., & Springett, J. (2006). From rhetoric to reality: A systemic approach to understanding the constraints faced by Health For All initiatives in England. *Social Science & Medicine, 63*, 178-188.

Bernard, P., Charafeddine, R., Frohlich, K. L., Daniel, M., Kestens, Y., & Potvin, L. (2007). Health inequalities and place: A theoretical conception of neighbourhood. *Social Science & Medicine, 65*, 1839-1852.

BIG Lottery Fund. (2006a). *The Well-being programme: Guidance notes*. Retrieved July 01, 2011, from http://www.biglotteryfund.org.uk/prog_well_being_gn.pdf

BIG Lottery Fund. (2006b). *Well-being: An introduction to our new programme*. Retrieved July 01, 2011, from http://www.biglotteryfund.org.uk/prog_well_being_leaflet.pdf

Billis, D., & Glennerster, H. (1998). Human services and the voluntary sector: Towards a theory of comparative advantage. *Journal of Social Policy, 27*, 79-98.

Black, D., Townsend, P., & Morris, J. (1980). *Inequalities in health: Report of a research working group*. London: Department of Health and Social Security.

Black, N. (2001). Evidence based policy: Proceed with care. *British Medical Journal, 323*, 275–279.

Blair, T. (1997). *Bringing Britain together: Speech by the Prime Minister, The Rt Hon Tony Blair MP*. Retrieved April 23, 2010, from http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/pm_speech_seu.pdf

Blair, T. (1998). *The third way: New politics for the new century*. London: Fabian Society.

Bloyce, D., & Murphy, P. (2007). Involvement and detachment, from principles to practice: A critical reassessment of The Established and the Outsiders. [Book Review]. *Irish Journal of Sociology, 16*, 3-21.

Bloyce, D., & Smith, A. (2010). *Sport Policy and Development: An introduction*. Abingdon: Routledge.

Bloyce, D., Smith, A., Mead, R., & Morris, J. (2008). 'Playing the game (plan)': A figurational analysis of organizational change in sports development in England. *European Sport Management Quarterly, 8*, 359-378.

Blumer, H. (1954). What is wrong with social theory. *American sociological review, 19*, 3-10.

Blumer, H. (1969). *Symbolic interaction*. Englewood Cliffs, NJ: Prentic-Hall.

Boa, I., Johnson, P., & King, S. (2010). *The impact of research on the policy process*. London: Department for Work and Pensions.

Bonner, L. (2003). Using theory-based evaluation to build evidence-based health and social care policy and practice. *Critical Public Health, 13*, 77-92.

Bottero, W. (2009). Relationality and social interaction. *British Journal of Sociology, 60*, 399-420.

Bottero, W. (2010). Intersubjectivity and Bourdieusian approaches to 'identity'. *Cultural Sociology, 4*, 3-22.

Bourdieu, P. (1986). The forms of capital. In J. Richardson, G. (Ed.), *Handbook of theory and reserach for the soicology of education* (pp. 241-258). New York: Greenwood Press.

Bourner, T. (1996). The research process: Four steps to success. In T. Greenfield (Ed.), *Research methods: Guidance for postgraduates*. London: Arnold.

Bovaird, T. (2007). Beyond engagement and participation: User and community coproduction of public services. *Public Administration Review, 67*, 846-860.

Bowes, A. M. (1996). Evaluating an empowering research strategy: Reflections on action-research with South Asian Women. *Sociological Research Online, 1*(1). Retrieved from http://www.socresonline.org.uk/1/1/1.html

Boydell, L. R., & Rugkåsa, J. (2007). Benefits of working in partnership: A model. *Critical Public Health, 17*, 217-228.

Brandsen, T., & Pestoff, V. (2006). Co-production, the third sector and the delivery of public services: An introduction. *Public Management Review, 8*, 493-501.

British Sociological Association. (2002). *Statement of ethical practice for the British Sociological Association.* Retrieved January 21, 2011, from http://www.britsoc.co.uk/equality/Statement+Ethical+Practice.htm

Brook, R. (1987). Justice and the golden rule: A commentary on some recent work of Lawrence Kohlberg. *Ethics, 97*, 363-373.

Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research, 6*, 97-113.

Bryman, A. (2008). *Social research methods* (3 ed.). New York: Oxford University Press.

Buck, N. (2001). Identifying neighbourhood effects on social exclusion. *Urban studies, 38*, 2251-2275.

Burton, P., Croft, J., Hastings, A., Slater, T., Goodlad, R., Abbott, J., & Macdonald, G. (2004). *What works in community involvement in area-based initiatives? A systematic review of the literature.* Retrieved April 23, 2010, from http://rds.homeoffice.gov.uk/rds/pdfs04/rdsolr5304.pdf

Burton, P., Goodlad, R., & Croft, J. (2006). How would we know what works? Context and complexity in the evaluation of community involvement. *Evaluation, 12*, 294-312.

Buse, K., Mays, N., & Walt, G. (2005). *Making health policy*. Maidenhead: Open University Press.

Byrne, D. (2001). Complexity science and transformations in social policy *Social Issues, 1*(2). Retrieved from www.whb.co.uk/socialissues/index.htm

Cabinet Office. (2010). *Building the Big Society.* Retrieved 22/03/11, from http://www.cabinetoffice.gov.uk/news/building-big-society

Cameron, A., & Lloyd, L. (2011). Are some boundaries easier to bridge? *Policy & Politics, 39*, 361-377.

Cameron, A., Lloyd, L., Turner, W., & Macdonald, G. (2009). Working across boundaries to improve health outcomes: A case study of a housing support and outreach service for homeless people living with HIV. *Health and Social Care in the Community (online version), 17*, 388-395.

Cameron, E., Mathers, J., & Parry, J. (2008). 'Health and well-being': questioning the use of health concepts in public health policy and practice. *Critical Public Health, 18*, 225-232.

Campbell, C., & Murray, M. (2004). Community health psychology: Promoting analysis and action for social change. *Journal of Health Psychology, 9*, 187-195.

Campbell, C., Wood, R., & Kelly, M. (1999). *Social capital and health*. London: Health Education Authority

Campbell, N. C., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., . . . Kinnmoth, A. L. (2007). Designing and evaluating complex interventions to improve health care. *British Medical Journal, 334*, 455-459.

Carlisle, D. (2003). Long division. *Health Services Journal, (Suppl.), March*, 4-6.

Carlisle, S. (2010). Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a Social Inclusion Partnership in Scotland. *Critical Social Policy, 20*, 117-127.

Carr-Hill, R., & Street, A. (2008). *Economic analysis of cost-effectiveness of community engagement to improve health, CHC Research Paper 33*. York: University of York.

Cattell, V. (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science & Medicine, 52*, 1501-1516.

Chadwick, E. (1843). *Report on the sanitary conditions of the laboruing population*. London: The Home Department.

Chapman, T., Brown, J., Ford, C., & Baxter, B. (2010). Trouble with champions: Local public sector-third sector partnerships and the future prospects for collaborative governance in the UK. *Policy Studies, 31*, 613-630.

Chappell, A. (2000). Emergence of participatory methodology in learning difficulty research: Understanding the context. *British Journal of Learning Disabilities, 28*, 38–43.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Chatterton, P., & Bradley, D. (2001). Bringing Britain Together? The limitations of area-based regeneration policies in addressing deprivation. *Local Economy, 15*, 98-111.

Checkland, K., Coleman, A., Harrison, S., & Hiroeh, U. (2009). 'We can't get anything done because...': Making sense of 'barriers' to practice-based commissioning. *Journal of Service Research Policy, 14*, 20-26.

Cheshire West and Chester Council. (2009a). *Area Partnership Board profile: Ellesmere Port.* Retrieved 08/04/2011, from www.westcheshiretogether.org.uk/pdf/EllesmerePortFinalV3.pdf

Cheshire West and Chester Council. (2009b). *Topic paper: Image, identity and tourism*. Retrieved July 29, 2012, from http://consult.cheshirewestandchester.gov.uk/portal/cwc_ldf/cwc_cs/cs_io/tp_iit_io?pointId=801032

Cheshire West and Chester Council. (2010). *Total Place: Key statistics for Ellesmere Port*. from http://www.westcheshiretogether.org.uk/PDF/Total_Place_Profile_10_03_10.pdf

Cheshire West and Chester Council and NHS Western Cheshire. (n.d). *People living alone in Cheshire West and Chester*. Retrieved September 3, 2012, from www.doriconline.org.uk/...d0.../get/ShowResourceFile.aspx

Christakis, N. A., & Fowler, J. H. (2007). The spread of obesity in a large social network over 32 Years. *New England Journal of Medicine, 357*, 370-379.

Coalter, f. (2007). Sports Clubs, social capital and social regeneration: 'Ill-defined interventions with hard to follow outcomes'? *Sport in Society, 10*, 37-559.

Coburn, D. (2004). Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Social Science & Medicine, 58*, 41-56.

Coburn, D. (2011). Health inequalities: a response to Scambler. *Sociology of Health & Illness, 34*, 149-150.

Coe, C., Gibson, A., Spencer, N., & Stuttaford, M. (2008). Sure Start: voices of the 'hard-to-reach'. *Child: Care, Health & Development, 34*, 447-453.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: complementary research strategies*. London: Sage.

Communities and Local Government. (2010). *Indices of deprivation 2010*. Retrieved September 1, 2012, from http://www.doriconline.org.uk/ViewPage.aspx?c=datasetinformation&did=503&v=1366

Communities and Local Government. (n.d.). *Third sector, community and voluntary groups.* Retrieved June 5, 2010, from http://www.communities.gov.uk/communities/thirdsector/

Connell, J. P., & Kubisch, A. C. (1998). Applying a theory of change approach to the evaluation of comprehensive community intitiaves: Progress, prospects and problems. In K. Fullbright-Anderson & A. C. Kubisch (Eds.), *New approaches to evaluating community initiatives. Vol 2 theory, measurement and analysis*. Washington DC: The Aspen Institute.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209-232.

Cornwell, A., & Jewkes, R. (1995). What is participatory research? *Social Sciences and Medicine, 41*, 1667- 1676.

Costongs, C., & Springett, J. (1997). Joint working and the production of a City Health Plan: the Liverpool experience. *Health Promotion International, 12*, 9-19.

Cox, E., & Schmuecker, K. (2010). *Rebalancing local economies: Widening economic opportunities for people in deprived communities*. Institute for Public Policy Research North.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services, 10*, 365-389.

Crawshaw, P., Bunton, R., & Gillen, K. (2003). Health Action Zones and the problem of community. *Health and Social Care in the Community, 11*, 36-44.

Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research* (2nd ed.). London: Sage.

Cummins, S., Curtis, S., Diez-Roux, A., & Macintyre, S. (2007). Understanding and representing 'place' in health research: A relational approach. *Social Science & Medicine, 65*, 1825-1838.

Curtis, S., & Rees Jones, I. (1998). Is there a place for geography in the analysis of health inequality? *Sociology of Health and Illness, 20*, 645-672.

Dabinett, G., Lawless, P., Rhodes, J., & Tyler, P. (2004). *A review of the evidence base for regeneration policy and practice*. Retrieved June 13, 2010, from http://webarchive.nationalarchives.gov.uk/+/http://www.communities.gov.uk/archived/general-content/citiesandregions/review/

Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health*. Stockholm: Institute for Futures Studies.

de Swaan, A. (2001). *Human societies: an introduction*. Cambridge: Polity Press.

Denscombe, M. (1998). *The good research guide for small-scale social research projects*. Buckingham: Open University Press.

Department for Communities and Local Government. (2006). *Strong and prosperous communities: The local government White Paper*. London: The Stationary Office.

Department for Culture Media and Sport. (2010). *National Lottery*. Retrieved July 01, 2011, from http://www.culture.gov.uk/what_we_do/national_lottery/default.aspx

Department for Social Security. (1998). *A new contract for welfare: Partnership in pensions*. London: Department for Social Security.

Department of Health. (1992). *The Health of the Nation: A strategy for England*. London: The Stationary Office.

Department of Health. (1995). *Variations in health: What can the Department of Health and the NHS do?* London: Department of Health.

Department of Health. (1997). *Health Action Zones: Inviation to bid*. Retrieved July 25, 2011, from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4011359.pdf

Department of Health. (1999a). *Reducing health inequalities: An action Report*. London: Department of Health.

Department of Health. (1999b). *Saving lives: Our healthier nation*. London: Department of Health.

Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform*. London: Department of Health.

Department of Health. (2001). *Tackling health inequalities: Consultation on a plan for delivery*. London: The Stationary Office.

Department of Health. (2003). *Tackling health inequalities: A programme for action*. London: Department of Health.

Department of Health. (2004). *Choosing health: Making healthy choices easier*. London: Department of Health.

Department of Health. (2010a). *Health profile of England 2009*. from http://www.dh.gov.uk/publications

Department of Health. (2010b). *Healthy lives, healthy people: Our strategy for public health in England*. London: The Stationary Office.

Dinham, A. (2005). Empowered or over-powered? The real experiences of local participation in the UK's New Deal for Communities. *Community Development Journal, 40*, 301-312.

Dooris, M. (2004). Joining up settings for health: A valuable investment for strategic partnerships? *Critical Public Health, 14*, 37-49.

Dopson, S. (2001). Applying an Elisian approach to oganizational analysis. *Organization, 8*, 515-535.

Dopson, S. (2003). The potential of the case study method for organizational analysis. *Policy & Politics, 31*, 217-226.

Dopson, S. (2005). The diffusion of medical interventions: Can figurational sociology contribute? *Organization Studies, 26*, 1125-1144.

Dopson, S., & Waddington, I. (1996). Managing social change: A process-sociological approach to understanding organisational change within the National Health Service. *Sociology of Health and Illness, 18*, 525-550.

Dorling, D. (1997). *Changing mortality ratios in local areas of Britain 1950s -1990s*. York: Joseph Rowntree Foundation.

Dorling, D. (2010). Using the concept of 'place' to understand and reduce health inequalities. In F. Campbell (Ed.), *The social determinants of health and the role of local government*. London: Improvement and Development Agency.

Dorling, D., Mitchell, R., Shaw, M., Orford, S., & Smith, G. D. (2000). The Ghost of Christmas Past: Health effects of poverty in London in 1896 and 1991. *BMJ, 321*, 1547-1551.

Dowling, B., Powell, M., & Glendinning, C. (2004). Conceptualising successful partnerships. *Health and Social Care in the Community, 12*, 309-317.

Dunne, C. (2011). The place of the literature review in grounded theory research. *International Journal of Social Research Methodology, 14*, 111-124.

Dunning, E., & Waddington, I. (2003). Sport as a drug and drugs in sport. *Internattional Review for the Sociology of Sport, 38*, 351-368.

Eide, P., & Kahn, D. (2008). Ethical issues in the qualitative researcher-participant relationship. *Nursing Ethics, 15*, 199-207.

Elias, N. (1978). *What is sociology?* London: Hutchinson & Co.

Elias, N. (1987). Problems of involvement and detachment. In *Involvement and detachment: Contributions to the sociology of knowledge.* (pp. 3-11). Oxford: Blackwell.

Elias, N. (1991). *The society of individuals*. New York: Continuum.

Elias, N. (1994). *The civilizing process: The history of manners and state formation and civilization*. Oxford: Blackwell.

Elias, N. (1997). *The Germans: Power struggles and the development of habitus in the nineteenth and twentieth centuries*. London: Polity Press.

Elias, N., & Scotson, J. L. (1965). *The established and the outsiders*. London: Sage.

Ellesmere Port and Neston Borough Council. (2009). *Area action plan consultation*. Retrieved May 11, 2011, from http://consult.cheshirewestandchester.gov.uk/portal/cwc_ldf/cep_aap_io/cep_aap_po?pointId=389093#document-389093

Engels, F. (1844). *The condition of the working-class in England in 1844*. Retrieved March 6, 2012, from http://www.gutenberg.org/files/17306/17306-h/17306-h.htm

English Partnerships: The National Regeneration Agency. (2008). *Urban Development Corporations.* Retrieved June 13, 2010, from http://www.pas.gov.uk/pas/core/page.do?pageId=12587

Evans, D. (2007). New directions in tackling inequalities. In J. Orm, J. Powell, P. Tyalor & M. Grey (Eds.), *Public health for the 21st century: New perspectives on policy, participation and practice*. Maidenhead: Open University Press.

Forbes, A., & Wainwright, S. P. (2001). On the methodological, theoretical and philosophical context of health inequalities research: A critique. *Social Science & Medicine, 53*, 801-816.

Fraser, D. (2009). *The evolution of the British welfare state: A history of social policy since the industrial revolution* (4th ed.). Hampshire: Palgrave Macmillan.

Gabe, J., Bury, M., & Elston, M. A. (2004). *Key concepts in medical sociology*. London: Sage.

Garbers, C., Tunstill, J., Allnock, D., & Akhurst, S. (2006). Facilitating access to services for children & families: Lessons from Sure Start Local Programmes. *Child and Family Social Work, 11*, 287-296.

Gatrell, A., Thomas, C., Bennett, S., Bostock, L., Popay, J., Williams, G., & Shahtahmasebi, S. (2000). Understanding health inequalities: Locating people in geographical and social spaces. In H. Graham (Ed.), *Understanding Health Inequalities* (pp. 156-169). Buckingham: Open University Press.

Gibbs, G. (2007). *Analyzing qualitative data*. London: Sage.

Giddens, A. (1998). *The third way*. Cambridge: Polity Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Glennerster, H., Lupton, R., Noden, P., & Power, A. (1999). *Poverty, social exclusion and neighbourhood: Studying the area bases of social exclusion*. Centre for Analysis of Social Exclusion: London School of Economics.

Gold, R. L. (1958). Roles in sociological field observations. *Social Forces, 36*, 217-223.

Goodman, A., Johnson, P. and Webb, S. (1997). *Inequality in the UK*. Oxford: Oxford University Press.

Goudsblom, J. (1977). *Sociology in the balance*. Oxford: Blackwell.

Government Offices for the English Regions. (no date). *Area-based initiatives*. Retrieved July 7, 2009, from http://www.gos.gov.uk/ournetwork/abis/?view=Standard

Grady, C. (2001). Money for research participation: Does it jeopardize informed consent? *The American Journal of Bioethics, 1*, 40-44.

Granovetter, M. S. (1973). The strength of weak ties. *American Journal of Sociology, 78*, 1360-1380.

Gray, S. (2007). The contribution of health services to public health. In J. Orme, J. Powell, P. Tyalor & M. Grey (Eds.), *Public helath for the 21st century: New perspectives on policy, participation and practice*. Maidenhead: Open University Press.

Green, A. E., & Owen, D. (2006). *The geography of poor skills and access to work*. York: Joseph Rowntree Foundation.

Green, A. E., & White, R. J. (2007). *Attachment to place: Social networks, mobility and prospects of young people*. York: Joseph Rowntree Foundation

Greenwood, D., Packham, C., Muir, K., & Madeley, R. (1995). How do economic status and social support influence survival after the initial recovery from acute myocardial infraction? *Social Science & Medicine, 40*, 639-647.

Groundwork North West. (2011). *Target Wellbeing Statistics Report for Ellesmere Port (available from Groundwork North West, 57 Hilton Street, Manchester, Greater Manchester M1 2EJ)*.

H M Treausry. (2004). *Exploring the third sector in public service delivery and reform: A discussion document*. London: H M Treasury.

Halfpenny, P., & Reid, M. (2002). Reserach on the voluntary sector: An overview. *Policy & Politics, 30*, 533-550.

Hall, S. (2000). The way forward for regeneration?: Lessons from the single regeneration budget challenge fund. *Local Government Studies, 26*, 1 - 14.

Hardiker, N. R., McGrath, M., & McQuarrie, C. (2009). *A synthesis of grey literature around public health interventions and programmes*. Salford: University of Salford.

Harris, M., & Young, P. (2010). Building bridges: The third sector responding locally to diversity. *Voluntary Sector Review, 1*, 41-58.

Harting, J., & van Assema, P. (2010). Exploring the conceptualization of program theories in Dutch community programs: A multiple case study. *Health Promotion International, 26*, 23-36.

Health Development Agency. (2004). *Lessons from Health Action Zones*. London: Health Development Agency.

Heins, E., Price, D., Pollock, A. M., & Miller, E. (2010). A review of the evidence of third sector performance and its relevance for a universal comprehensive health system. *Social Policy and Society, 9*, 515-526.

Hills, J., Brewer, M., Jenkins, S., Lister, R., Lupton, R., Machin, S., . . . Riddell, S. (2010). *An anatomy of economic inequality in the UK: Report of the National Equality Panel*. London: Government Equalities Office.

HM Treasury. (2002). *The role of the voluntary and community sector in service delivery: A cross cutting review.* London: The Stationary Office.

Hobbs, R. (1988). *Doing the business*. Oxford: Oxford University Press.

Hood, C. (1995). The “new public management” in the 1980s: Variations on a theme. *Accounting, Organizations and Society, 20*, 93-109.

Hothi, M., Woodcraft, S., with Cordes, C., & Muskett, D. (2010). *The end of regeneration? Improving what matters on small housing estates*. London: The Young Foundation.

House of Commons Public Administration Select Committee. (2008). *Public Services and the third sector: Rhetoric and reality*. London: The Stationary Office.

Hoyt, L., & Leroux, A. (2007). *Voices from forgotten cities: Innovative revitalization coalitions in America’s older small cities*. Cambridge Massachusetts: MIT School of Architecture and Planning.

Humphreys, E. (2007). Social capital in disadvantaged neighbourhoods: A diversion from needs or a real contribution to the debate on area-based regeneration? *Irish Journal of Sociology, 16*, 50-76.

Hunter, D. J. (2007). Public health policy. In J. Orme, J. Powell, P. Taylor & M. Grey (Eds.), *Public Health For The 21st Century: New perspectives on policy, participation and practice* (pp. 25-41). Maidenhead: McGraw-Hill/Open University Press.

Hunter, D. J. (2008). *The health debate: Policy and politics in the twenty-first century*. Bristol: The Policy Press.

Illich, I. D. (1977). *Limits to medicine, medical nemesis: The expropriation of health*. Harmondsworth: Penguin.

International Wellbeing Group. (2006). *Personal Wellbeing Index*. Retrieved March 7, 2012, from http://www.deakin.edu.au/research/acqol/instruments/wellbeing_index.htm

Jones, K., & Duncan, C. (1995). Individuals and their ecologies: Analysing the geography of chronic illness within a multilevel modelling framework. *Health & Place, 1*, 27-40.

Joseph Rowntree Foundation. (2003). *Shaping our lives – from outset to outcome: What people think of the social care services they use*. York: Joseph Rowntree Foundation.

Joseph Rowntree Foundation. (2005). *Policies towards poverty, inequality and exclusion since 1997*. York: JRF.

Joshi, H., Wiggins, R. D., Bartley, M., Mitchell, R., Gleave, S., & Lynch, K. (2000). Putting health inequalities on the map: does where you live matter and why? In H. Graham (Ed.), *Understanding health inequalities* (pp. 143-155). Buckingham: Open University Press.

Judge, K., & Bauld, L. (2001). Strong theory, flexible methods: Evaluating complex community-based initiatives. *Critical Public Health, 11*, 19-38.

Judge, K., & Bauld, L. (2006). Learning from Policy Failure? Health Action Zones in England. *European Journal of Public Health, 16*, 341.

Julia, C., & Valleron, A. (2009). Louis-Rene Villerme (1782 – 1863), a pioneer in social epidemiology: Re-analysis of his data on comparative mortality in Paris in the early 19th century *Journal of Epidemiological Community Health, 65*, 666-670.

Kavanaugh, K., Moro, T. T., Savage, T., & Mehendale, R. (2006). Enacting a theory of caring to recruit and retain vulnerable participants for sensitive research. *Research in Nursing & Health, 29*, 244-252.

Keen, J., & Packwood, T. (1995). Case study evaluation. *British Medical Journal, 311*, 444-446.

Kitchin, R. (2002). The researched opinions on research: Disabled people and disability research. *Disability and Society, 15*, 25–47.

Korgevinas, E., & Porta, M. (1997). Socioeconomic differences in cancer survival: A review of the evidence. In M. Kogevinas, N. Pearce, M. Susser & P. Boffetta (Eds.), *Social Inequalities and Cancer*. Lyon: International Agency for Research on Cancer.

Lansley, A. (2010, July 7). *A new approach to public health: Speech to the Faculty of UK Public Health.* Retrieved 14/09/10, from http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_117280

Lawless, P. (2002). *New Deal for Communities national evaluation: NDC partnership reports: A Synthesis*. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University.

Lawless, P. (2004). Locating and explaining area-based urban initiatives: New Deal for Communities in England. *Environment and Planning C: Government and Policy, 22*, 383-399.

Lawless, P. (2006). Area-based urban interventions: Rationale and outcomes: The New Deal for Communities programme in England. *Urban Studies, 43*, 1991-2011.

Lawless, P. (2011). *Regeneration: What are the problems and what can we achieve in addressing them? Neighbourhood level perspectives from the NDC Programme*. London: Department for Communities and Local Government.

Lawless, P., & Dabinett, G. (2000). *A review of the evidence base for regeneration policy and practice*. London Office of the Deputy Prime Minister.

Lawson, H. (1983). Towards a model of teacher socialisation in physical education: The subjective warrant, recruitment, and teacher education. *Journal of Teaching in Physical Education, 2*, 3-16.

Lester, H., Birchwood, M., Tait, L., Shah, S., England, E., & Smith, J. (2008). Barriers and facilitators to partnership working between Early Intervention Services and the voluntary and community sector. *Health and Social Care in the Community, 16*, 493–500.

Lizardo, O. (2004). The cognitive origins of Bourdieu's habitus. *Journal for the Theory of Social Behaviour, 43*, 375-401.

Lloyd, G., & Black, S. (1993). Property-led urban regeneration and local economic development. In J. Berry, S. McGreal & B. Deddis (Eds.), *Urban regeneration: Property Investment and Development* (pp. 144-160). London: E & FN Spoon.

London Health Observatory. (2010). *Jubilee line of health inequality 2004-2008*. Retrieved 1, October, 2012, from http://www.lho.org.uk/viewResource.aspx?id=15463

Love, J. M., Kisker, E. E., Ross, C. M., & Schochet, P. Z. (2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start*. Princeton: Mathematica Policy Research, Inc.

Macintyre, S., Ellaway, A., & Cummins, S. (2002). Place effects on health: how can we conceptualise, operationalise and measure them? *Social Science & Medicine, 55*, 125-139.

Macintyre, S., MacIver, S., & Sooman, A. (1993). Area, class and health: Should we be focusing on places or people? *Journal of Social Policy, 22*, 213-234.

Mackenbach, J. P. (2006). *Health Inequalities: Europe in Profile*. London: Department of Health.

MacLeavy, J. (2008). Neoliberalising subjects: The legacy of New Labour's construction of social exclusion in local governance. *Geoforum, 39*, 1657-1666.

Macmillan, L. (2009). *Fathers and sons: Can worklessness be transmitted across generations?* Bristol: Centre for Market and Public Organisation, University of Bristol.

Magnani, N., & Struffi, L. (2009). Translation sociology and social capital in rural development initiatives. A case study from the Italian Alps. *Journal of Rural Studies, 25*, 231-238.

Maguire, J. (1988). Doing figurational sociology: Some preliminary observations on methodological issues and sensitising concepts. *Leisure Studies, 7*, 187-193.

Mandelson, P. (1997). *Labour's next steps: Tackling social exclusion. Speech to the Fabian Society August 14, 1997*. Retrieved March 6, 2012, from http://lib-161.lse.ac.uk/archives/fabian_tracts/581.pdf

Manor, O., Matthews, S., & Power, C. (1997). Comparing measures of health inequality. *Social Science & Medicine, 45*, 761-771.

Marmot, M. (2010). *Fair society, healthy lives: The Marmot review*. London: The Marmot Review.

Marmot, M., Rose, G., Shipley, M., & Hamilton, P. J. S. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology and Community Health, 32*, 244-249.

Mason, J. (2002). Sampling and selection in qualitative research. In J. Mason (Ed.), *Qualitative researching*. London: Sage.

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research, 6*, 9-25.

Massey, D. (2005). *For space*. London: Sage.

May, D. M. (2004). The interplay of three established-outsider figurations in a deprived inner-city neighbourhood. *Urban Studies, 41*, 2159-2179.

Mays, N., & Pope, C. (2000). Qualitative research in healthcare: Assessing quality in qualitative research. *British Medical Journal, 320*, 50-50.

McCulloch, A., Mohan, J., & Smith, P. (2012). Patterns of social capital, voluntary activity, and area deprivation in England. *Environment and Planning C: Government and Policy, 44*, 1130–1147.

McKenzie, L. (2012). A narrative from the inside, studying St Anns in Nottingham: Belonging, continuity and change. *The Sociological Review, 60*, 457–475.

McKeown, T. (1976). *The role of medicine: Dream, mirage or nemesis*. London: Nuffield Provincial Hospital Trust.

McLennan, D., Barnes, H., Noble, M., Davies, J., & Garratt, E. (2011). *The English Indices of Deprivation 2010: Technical report*. Retrieved Spetember 1, 2012, from http://www.communities.gov.uk/publications/corporate/statistics/indices2010technicalreport

McPherson, M., Smith-Lovin, L., & Brashears, M. E. (2006). Social isolation in America: Changes in core discussion networks over two decades. *American Sociological Review, 71*, 353-375.

Melhuish, E., Belsky, J., Anning, A., Ball, M., Barnes, J., Romaniuk, H., & Leyland, A. (2007). Variation in community intervention programmes and the consequences for children and families: The example of Sure Start Local Programmes. *Journal of Child Psychology and Psychiatry, 48*, 543-551.

Mennell, S. (1992). *Norbert Elias: An introduction*. Dublin: University College Dublin Press.

Merzel, C., & D'Afflitti, J. (2003). Reconsidering community-based health promotion: Promise, performance, and potential. *American Journal of Public Health, 93*, 557-574.

Mickledore Ltd. (2011). *Cheshire West and Chester Council: Local economic assessment story of place*. Retrieved September 1, 2012, from www.investincheshire.com/downloads/CWAC_LEA_Story.pdf

Micklewright, J. (2002). *Social Exclusion and Children: A European view for a US debate*. London School of Economics: Centre for Analysis of Social Exclusion.

Milbourne, L. (2009). Remodelling the third sector: Advancing collaboration or competition in community-based initiatives? *Journal of Social Policy, 38*, 277-297.

Milburn, A. (2002, November 20). *Tackling helath inequalities, improving public health. Speech to the faculty of Public Health Medicine*. Retrieved November 5, 2012, from http://www.guardian.co.uk/society/2002/nov/20/publichealth

Milton, B., Moonan, M., Robinson, D. T., & Whitehead, M. (2010). *How can the health equity impact of universal policies be evaluated? Insights into approaches and next steps.* Proceedings of the Expert Group Meeting, University of Liverpool.

Mitchell, J. C. (1983). Case and situation analysis. *The Sociological Review, 31*, 187-211.

Moore, S., Haines, V., Hawe, P., & Shiell, A. (2006). Lost in translation: A genealogy of the 'social capital' concept in public health. *Journal of Epidemiology & Community Health, 60*, 729-734.

Mowles, C. (2011). Planning to innovate: Designing change or caught up in a game? *Perspectives in Public Health, 131*, 119-123.

Mulhall, A. (2003). In the field: Notes on observation in qualitative resarch. *Journal of Advanced Nursing, 41*, 306-313.

National Council for Voluntary Organisations. (2010). *Voluntary Sector services not a soft option for cuts*. Retrieved June 9, 2010, from http://www.ncvo-vol.org.uk/news/civil-society/voluntary-sector-services-not-soft-option-cuts

National Evaluation of Sure Start Team. (2010). *The impact of Sure Start Local Programmes on five year olds and their families*. London: Institute for the Study of Children, Families and Social Issues, Birkbeck University of London.

National Institute for Health and Clinical Excellence. (2008). *Community engagement to improve health*. London: National Institute for Health and Clinical Excellence.

National Research Ethics Service. (2009). *Welcome to the National Research Ethics Service.* Retrieved 21.1.11, from http://www.nres.npsa.nhs.uk/

Nazroo, J. (2003). The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism. *American Journal of Public Health, 93*, 277-284.

NHS Western Cheshire. (2012). *Dataset: Life expectancy at birth (Cheshire and Warrington)*. Retrieved September 1, 2012, from http://www.doriconline.org.uk/Viewdata.aspx?P=Data&referer=%2fBuildDataView.aspx%3fDataSetID%3d525%26VariableID%3d1391

Noble, M., McLennan, D., Wilkinson, K., Whitworth, A., & Barnes, H. (2008). *The English Indices of Deprivation 2007*. Retrieved August 31, 2012, from http://www.communities.gov.uk/documents/communities/pdf/733520.pdf

North, F. M., Syme, S. L., Feeney, A., Shipley, M., & Marmot, M. (1996). Psychosocial work environment and sickness absence among British civil servants: the Whitehall II study. *American Journal of Public Health, 86*, 332-340.

Northwest Regional Development Agency. (2009). *Northwest places: Ellesmere Port*. Retrieved May 11, 2011, from http://www.nwriu.co.uk/PDF/Ellesmere_Port_-_Oct_2009.pdf

O'Corry, O. (2010). Defining and theorizing the third sector. In R. Taylor (Ed.), *Third Sector Research* (pp. 11-20). London: Springer.

O'Dwyer, L., Baum, F., Kavanagh, A., & Macdougall, C. (2007). Do area-based interventions to reduce health inequalities work? A systematic review of evidence. *Critical Public Health, 17*, 317-335.

Oakley, A. (1999). People's ways of knowing. In B. M. Suzanne Hood, and Sandy Oliver (Ed.), *Critical issues in social research: Power and prejudice* (pp. 154-170). Buckingham: Open University Press.

Office for National Statistics. (2010). *Population Estimates for UK, England and Wales, Scotland and Northern Ireland - mid 2007*. Retrieved August 27, 2012, from http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-213833

Office of the Deputy Prime Minister. (2005). *ABI guidance to departments: Guidance on the design and co-ordination of area based initiatives and local partnership based programmes*. London: The Stationary Office.

Oliver, P. (2003). *The student's guide to research ethics*. Philadelphia: Open University Press.

Orme, J., Powell, J., Taylor, P., & Grey, M. (2007). Mapping public health. In J. Orme, J. Powell, P. Tyalor & M. Grey (Eds.), *Public health for the 21st century: New perspectives on policy, participation and practice*. Maidenhead: Open University Press.

Parry, J. (2004). Mechanisms by which area-based regeneration programmes might impact on community health: a case study of the new deal for communities initiative. *Public Health, 118*, 497-505.

Paulle, B., van Heerikhuizen, B., & Emirbayer, M. (2012). Elias and Bourdieu. *Journal of Classical Sociology, 12*, 69-93.

Pawson, R., & Tilley, N. (1997). *Realistic evaluation*. London: Sage.

Perkins, N., Smith, K., Hunter, D. J., Bambra, C., & Joyce, K. (2010). 'What counts is what works'? New Labour and partnerships in public health. *Policy and Politics, 38*, 101-117.

Perry, C., Thurston, M., & Green, K. (2004). Involvement-detachment and researching sexuality. *Qualitative Health Research, 14*, 135-148.

Petticrew, M. (2011). When are complex interventions 'complex'? When are simple interventions 'simple'? *European Journal of Public Health, 21*, 397-399.

Phillimore, P. (1994). Widening inequality of health in northern England, 1981-91. *British Medical Journal, 308*, 1125-1128.

Poortinga, W. (2012). Community resilience and health: The role of bonding, bridging, and linking aspects of social capital. *Health & Place, 18*, 286-295.

Popay, J. (2006). Community engagement for health improvement: Questions of definition outcomes and evaluation. A background paper prepared for NICE. Retrieved from http://www.nice.org.uk/niceMedia/pdf/smt/070306item13.pdf

Popay, J., Thomas, C., Williams, G., Bennett, S., Gatrell, A., & Bostock, L. (2003a). A proper place to live: health inequalities, agency and the normative dimensions of space. *Social Science & Medicine, 57*, 55-69.

Popay, J., Thomas, C., Williamson, D. L., Bennett, S., Gatrell, A., & Bostock, L. (2003b). A proper place to live: Health inequalities, agency and the normative dimensions of space. *Social Science & Medicine, 57*, 55-69.

Popay, J., Williams, G., Thomas, C., & Gatrell, A. (1998). Theorising inequalities in health: The place of lay knowledge. *Sociology of Health and Illness, 20*, 619-644.

Pope, C., & Mays, N. (1995). Qualitative reserach: Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *British Medical Journal, 311*, 42-45.

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *British Medical Journal, 320*, 114-116.

Popper, K. (1959). *The logic of scientific discovery*. London: Routledge.

Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology, 24*, 1-24.

Powell, M. (2000). New Labour and the third way in the British welfare state: A new and distinctive approach? *Critical Social Policy, 20*, 39-60.

Powell, M., Boyne, G., & Ashworth, R. (2001). Towards a geography of people poverty and place poverty. *Policy & Politics, 29*, 243-258.

Powell, M., & Moon, G. (2001). Health Action Zones: the 'third way' of a new area-based policy? *Health and Social Care in the Community (online version), 9*, 43-50.

Power, S., Rees, G., & Taylor, C. (2005). New Labour and educational disadvantage: The limits of area-based initiatives. *London Review of Education, 3*, 101-116.

Putnam, R. (2000). *Bowling alone: The collapse and revival of American community*. New Y ork: Simon and Schuster.

Quinn Patton, M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks: Sage.

Reay, D. (2004). `It's all becoming a habitus': beyond the habitual use of habitus in educational research. *British Journal of Sociology of Education, 25*, 431-444.

Reed-Danahay, D. (2005). *Loacting Bourdieu*. Bloomington: Indiana University Press.

Rhodes, J., Tyler, P., & Brennan, A. (2007). *The Single Regeneration Budget: Final Evaluation*. Retrieved March 19, 2012, from http://www.landecon.cam.ac.uk/research/reuag/uars/pdf/part1_final_eval_feb_07.pdf

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research. *Family Practice, 19*, 135-139.

Roberts, I., & Power, C. (1996). Does the decline in child injury mortality vary by social class? A comparison of class specific mortality in 1981 and 1991. *British Medical Journal, 313*, 784-786.

Sanderson, I. (2000). Access to services. In J. Percy-Smith (Ed.), *Policy responses to social exclusion* (pp. 130-147). Buckingham: Open University Press.

Savage, M. (2003). A new class paradigm. *British Journal of Sociology of Education, 24*, 535-541.

Science and Technology Select Committee. (2011). *Behaviour change*. London: The Stationary Office.

Scott-Samuel, A. (2000). *Health inequalities policy and politics under New Labour.* Retrieved April 15, 2010, from http://www.sochealth.co.uk/news/ukheg.htm

Scott, J. (1990). *A matter of record*. Cambridge: Polity.

Self, A., Thomas, J., & Randall, C. (2012). *Measuring national well-being: Life in the UK, 2012*. Office for National Statistics.

Shutz, A. (1962). *Concept and theory formation in the social sciences: Collected Papers Vol. 1*. The Netherlands: Martinus Nijhoff Publishers.

Simpson, A. (2002). *Sure Start Folkestone Local Evaluation 2002: Understanding barriers to service inclusion faced by local parents*. Retrieved November 24, 2012, from http://www.ness.bbk.ac.uk/support/local-evaluation-findings/documents/26.pdf

Sinclair, S. (2008). Dilemmas of community planning : Lessons from Scotland. *Public Policy and Administration, 23*, 373.

Skrabanek, P. (1994). *The dealth of human medicine and the rise of coercive healthism*. Bury St Edmunds: The Social Affairs Unit.

Smith, D. E. (2002). Institutional ethnography. In T. May (Ed.), *Qualitative research in action* (pp. 17-52). London: Sage.

Social Exclusion Taskforce. (2007). *Reaching out: An action plan on social exclusion* London: The Cabinet Office.

Social Exclusion Unit. (2001). *A new commitment to neighbourhood renewal: National strategy action plan*. London: The Cabinet Office.

Solar, O., & Irwin, A. (2007). *A conceptual framework for action on the social determinants of health: Discussion paper for the Commission on Social Determinants of Health*. Geneva: World Health Organization.

Springett, J. (2001). Appropriate approaches to the evaluation of health promotion. *Critical Public Health, 11*, 139-151.

Stafford, M., Gimeno, D., & Marmot, M. (2008). Neighbourhood characteristics and trajectories of health functioning: A mutilevel prospective analysis. *European Journal of Public Health, 18*, 604-610.

Stanton-Salazar, R. D. (2010). A Social Capital Framework for the Study of Institutional Agents and Their Role in the Empowerment of Low-Status Students and Youth. *Youth & Society, 43*, 1066-1109.

Stephens, C. (2007). Participation in different fields of practice. *Journal of Health Psychology, 12*, 949-960.

Stephens, C. (2008). Social capital in its place: Using social theory to understand social capital and inequalities in health *Social Science & Medicine, 66*, 1174-1184.

Steuer, N., & Marks, N. (2008). *Local wellbeing: Can we measure it?* London: New Economics Foundation.

Stewart, K., & Hills, J. (2005). Introduction. In J. Hills & K. Stewart (Eds.), *A more eqaul society: New Labour, poverty, inequality and social exclusion*. Bristol: The Policy Press.

Stewart, M. (2001). *Area based initiatives and urban policy*. Paper presented at the Danish Building and Urban Research and European Urban Research Association Conference, Copenhagen. http://www.sbi.dk/eura/workshops/murraystewart.htm

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks: Sage.

Sullivan, H., Barnes, M., & Matka, E. (2006). Collaborative capacity and strategies in area-based initiatives. *Public Administration, 84*, 289-310.
Filed ABI analysis.

Surko, M., Lawson, H. A., Gaffney, S., & Claiborne, N. (2006). Targeting evaluations of youth development-oriented community partnerships [Supplement]. *Journal of Public Health Management and Practice, 12* S95-S107.

Swann, C., & Morgan, A. (Eds.). (2002). *Social capital for health: Insights from qualitative research*. London: Health Development Agency.

Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology, 33*, 650-667.

Target Wellbeing. (n.d). *Ellesmere Port*. Retrieved Aug 31, 2012, from http://www.targetwellbeing.org.uk/profile/ellesmere_port

Tellis, W. (1997). Introduction to case study. *The Qualitative Report, 3*(2). Retrieved from http://www.nova.edu/ssss/QR/QR3-2/tellis1.html

The Labour Party. (1997). *New Labour because Britain deserves better: The Labour Party Manifesto*. London: The Labour Party.

Thomson, H. (2008a). A dose of realism for healthy urban policy: Lessons from area-based initiatives in the UK. *Journal of Epidemiology and Community Health 62*, 932-936.

Thomson, H. (2008b). A dose of realism for healthy urban policy: Lessons from area-based initiatives in the UK. *Journal of Epidemiology & Community Health, 62*, 932-936.

Thornton, H., Edwards, A., & Elwyn, G. (2003). Evolving the multiple roles of 'patients' in health care research: Reflections after involvement in a trial of shared decision making. *Health Expectations, 6*, 189–197.

Timpson, C., Knuckey, S., Perkins, C., Bellis, M., Dooris, M., & Farrier, A. (2011). *Target: Wellbeing Evaluation Update Report 2011*. Liverpool: North West Public Health Observatory.

Townsend, P. (1979). *Poverty in the United Kingdom*. London: Penguin Books.

Truman, C., & Raine, P. (2001). Involving users in evaluation: The social relations of user participation in health research. *Critical Public Health 11*, 215–229.

Tudor Hart, J. (1971). The inverse care law. *The Lancet, 297*, 405 - 412.

Unwin, J., & Westland, P. (2000). *Health Action Zones: The engagement of the voluntary sector*. London: The Baring Foundation.

van Krieken, R. (1998). *Norbert Elias*. New York: Routledge.

Waddington, I. (2000). *Sport, health and drugs: A critical sociological perspective*. London: E & FH Spon.

Wanless, D. (2002). *Securing our future health: Taking a long term view. final report.* London: HM Treasury.

Weber, M. (1947). *The theory of social and economic organization* (A. M. Henderson & T. Parsons, Trans.). New York: Free Press.

Weiss, C. H. (1995). Nothing as practical as good theory: Exploring theory-based evaluation for comprehensive community initiatives for children and families. In J. P. Connell, A. C. Kubisch, L. B. Schorr & C. H. Weiss (Eds.), *New approaches to evaluating community initiatives: Concepts, methods and contexts*. New York: Aspen Institute.

Western Cheshire Primary Care Trust. (2007). *Looking at the health of the population: Health review for Western Cheshire*. Chester: Western Cheshire Primary Care Trust.

Whitehead, M. (1988). *The health divide* London: Pelican Books.

Whitehead, M., & Drever, F. (1997). Life and death over the millennium. In M. Whitehead & F. Drever (Eds.), *Health inequalities: Decennial supplement (Series DS No. 5)* London: The Stationary Office.

Whittaker, K. A., & Cowley, S. (2012). An effective programme is not enough: a review of factors associated with poor attendance and engagement with parenting support programmes. *Children & Society, 26*, 138-149.

Wildridge, V., Childs, S., Cawthra, L., & Madge, B. (2004). How to create successful partnerships: A review of the literature. *Health Information and Libraries Journal, 21*, 3-19.

Wilkinson, R. G., & Pickett, K. E. (2010). *The spirit level: Why equality is better for everyone*. London: Penguin Books.

Wood, J., Hennell, T., Jones, A., Hooper, J., Tocque, K., & Bellis, M. A. (2006). *Where wealth means health: Illustrating inequality in the North West*. North West Public Health Observatory.

Woolcock, M. (1998). Social capital and economic development: Toward a theoretical synthesis and policy framework. *Theory and Society, 27*, 151-208.

World Health Organization. (1948). *Constitution of the World Health Organization.* Retrieved April 9, 2010, from http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

World Health Organization. (1986). *Ottawa Charter for health promotion*. Geneva: WHO.

Wouters, C., & van Stolk, B. (1987). Power changes and self-respect: a comparison of two cases of established-outsider relations. *Theory, Culture and Society, 4*, 477-488.

Yin, R. K. (2003). *Case study research: Design and methods*. Thousand Oaks: Sage.

Appendix 1

Ethical approval

Liverpool Paediatric Research Ethics Committee
Bishop Goss Complex
Victoria Building
Rose Place
Liverpool
L3 3AN

Telephone: 0151 330 2077
Facsimile: 0151 330 2075

29 May 2009

Miss Katie Powell
Phd student
University of Chester
University of Chester
Parkgate Road
Chester
Ch1 4BJ

Dear MISS POWELL

Full title of study: **The Target Wellbeing Programme in Ellesmere Port as a vehicle for social change: A sociological analysis of public health policy and practice**
REC reference number: **09/H1002/42**

Thank you for your letter of 11 May 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance

arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
References		
Referees or other scientific report - Repsonse to reviewers comments		
Referees or other scientific critique report - graduate school research proposal evaluation form		
Referees or other scientific critique report - graduate school research proposal evaluation form		
Letter from Funder - funded postgraduate research studentship in CPHR		28 October 2008
Participant Consent Form: Observation	1	16 March 2009
Participant Consent Form: Interview	1	16 March 2009
Participant Information Sheet: Interviews: Interviews information for local residents	2	11 May 2009
Participant Information Sheet: Interviews: Interviews information for service-users	2	10 May 2009
Participant Information Sheet: Interviews: Interviews information for service providers	2	11 May 2009
Participant Information Sheet: Researcher Observation: information sheet for people taking part in activities	2	11 May 2009
Participant Information Sheet: Researcher Observation: information sheet for service providers	1	16 March 2009
Letter of invitation to participant	1	16 March 2009
Advertisement	Living in Ellesmere Port?	16 March 2009
Letter from Sponsor		
Protocol	1	16 March 2009
Investigator CV		
Application	2.0	26 March 2009
Supervisor and financial arrangements (RO1PGR)		06 August 2008
Registration form (showing permission to access service - user database)		16 March 2009
UMAL - Insurance documents (provided by sponsor)		
Response to Request for Further Information		11 May 2009
Covering Letter		11 May 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H1002/42	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs J Harkin
Chair

Email: Ronald.Wall@liverpoolpct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *DR M HELSDON, University of Chester*
P. Elliott, Western Cheshire pct R&D office

Appendix 2

Non-participant observation sessions

Participants	Activity details	Venue	No. sessions
Footprints staff and/or users	Walking-to-music session	Independent Living Centre	2
	Autumn outdoor walk	Overpool area	1
	Skipping workshop	The Oaks Primary School	1
	Salsa lessons	The Oaks Primary School	1
Get Involved, Get Active staff and/or users	Drama group	Independent Living Centre	1
	Chair-based exercise	Overpool Community Centre	1
	Community fun day	Whitby Park	1
	Launch of voucher scheme	Leisure Centre	1
Grab a Bag staff and/or users	Fruit and vegetable bag collection session	Healthy Living Centre	1
Lots of Plots staff and/or users	Community Allotment site	Westminster Children's Centre	2
	Friends of Whitby Park (community group) meeting	Ellesmere Port Civic Hall	1
Mental health and wellbeing staff and/or users	Staff meeting	CHAPTER offices	1
	Allotment day	Allotment site	1

	West Cheshire Mental Health Forum	Quaker Meeting House	1
	Confidence course	Meadow Park Hospital	1
	Volunteer training day	Cheshire Sports Ground training rooms	1
	CHAPTER annual general meeting	Hoole Church Community Centre	1
Out and About staff and/or users	Friends of Westminster Park (community group) meeting	Ellesmere Port Conservative club	1
	Children's outdoor treasure hunt	Whitby Park	1
	Cycle training session	Westminster Primary School	1
Pathways staff and/or users	Job Centre recruitment event for lone parent work programmes	Fire Station	1
	Course interview	Job centre	1
	Employment course session	Association of VCS organisations training rooms	2
Health at Work staff and/or users	Workplace wellbeing consultation	Ellesmere Port library	2
Target Wellbeing portfolio providers and co-	Celebration events	Training venues	2

ordinators	Evaluation sub-group meetings	Groundwork North West offices	2
	Programme Managers meetings	Groundwork North West offices	1
	Evaluation training for providers	Groundwork North West offices	1
Ellesmere Port programme TW providers and co-ordinators	Programme meetings	Various community venues	11
	Collaborative working training	Ellesmere Port Civic Hall	1
	Programme Manager meeting with a portfolio co-ordinator	NHS Western Cheshire offices	1
Other Ellesmere Port service providers	Community Sports Network meeting	Ellesmere Port Civic Hall	1
	Area Partnership Board meeting		2
Local authority community workers	Impact' week community activities		1
	PCT Public Health team meeting	NHS Western Cheshire offices	1
Total			**52**

Appendix 3

Information sheets – observations

Research project: Target Wellbeing as a vehicle for social change

Katie Powell, University of Chester

Researcher observation: Information sheet for service providers

You are being asked for your consent for a researcher to observe some Target Wellbeing activities. Before you decide, it would help if you know why this research is being done and what will happen if you agree to the researcher observations. Please read this sheet and discuss it with others if you wish. You can contact the researcher if anything is unclear or if you would like more information.

What is the research for?
The research is being done to investigate what happens when an area-based initiative like Target Wellbeing is implemented in a local area. The intended and unintended consequences of the Target Wellbeing initiative will be explored with focus on the social networks between service providers and local residents in Ellesmere Port. The research hopes to provide some insight into what scope area-based initiatives provide for health improvement.

Who is carrying out and paying for the research?
Western Cheshire Primary Care Trust and the University of Chester are jointly funding this study. The research will be carried out by Katie Powell, based at the University of Chester, and will form the basis of her doctorate research (PhD). Professor Miranda Thurson is the supervisor for this study.

Why am I being approached?
You are being approached because you are involved in the delivery of the Target Wellbeing initiative in Ellesmere Port and the researcher would like to observe some activities at which you may be present.

What will happen if I agree to take part?
The researcher would like to interact with local providers and residents on an informal basis to get an idea of how Target Wellbeing is developing. With your agreement, the researcher will observe Target Wellbeing meetings, activities and informal conversations as a non-participant. Fieldwork notes and memos will be kept in order to record these informal interactions and to record the researcher's reflections on the processes taking place.

Do I have to take part?
Taking part is voluntary. If you do not take part it will not affect your work in any way. If you decide to take part you will be asked to sign a form to say you have read this information about the research. Even if you decide to take part, you can withdraw at any time without giving a reason.

What are the advantages and disadvantages of taking part?
You may find that the researcher's role as an observer of the project is helpful to the development of the Target Wellbeing initiative. We do not think there are any disadvantages in allowing the researcher to observe the Target Wellbeing events and activities.

Will my taking part be kept confidential?
All observations made by the researcher will be kept confidential. Field notes will only be accessible to the researcher and project supervisor. No names or details that could identify you would ever be used in any written or verbal reports.

What will happen to the results?
It is anticipated that the findings will be used to improve knowledge and understanding about area-based initiatives. The Primary Care Trust will use the findings to inform future health improvement work in the area. The findings will be presented in a PhD thesis and papers from the findings will be submitted to relevant academic journals. Summaries of the findings will be made available to people who take part.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the Faculty of Applied and Health Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

Who can I contact if I want more information?
If you would like to know more about the research you can contact the researcher, Katie Powell, Centre for Public Health Research, University of Chester, Parkgate Rd, Chester, CH1 4BJ. 01244 512058. k.powell@chester.ac.uk

Appendix 4

Observation schedule: TW activities

1. **Activity**
2. **Date/time**
3. **Venue (name/location/size/facilities)**
4. **Attendees (no./age/sex/any other information)**
5. **Session objectives/structure**
6. **What takes place?**
7. **How do(es) the facilitator(s) behave?**
8. **How do the participants respond to the activity?**
9. **Describe the group dynamics – between peers and with facilitator(s)**
10. **Activity debrief with facilitator(s)**
11. **Personal impressions of the session**

Appendix 5

List of documents analysed

Document title	Author(s)
Well-being: An introduction to our new programme	The BIG Lottery
BIG Well-being Fund programme guidance	The BIG Lottery
BIG Well-being Fund programme guidance - eligible and ineligible costs	The BIG Lottery
Bid development guidance to potential TW co-ordinators	Northwest Wellbeing Partnership
Bid development guidance to potential TW providers	Northwest Wellbeing Partnership
Invitation to submit TW project proposal	TW co-ordinator in Ellesmere Port
Ellesmere Port TW project appraisal panel meeting minutes	Meeting minute taker
Notes on unsuccessful Ellesmere Port bids	Ellesmere Port TW project bid appraisal panel members
Target Wellbeing regional portfolio strategy document/bid application	TW portfolio bid development team
TW area programme application form, Ellesmere Port	TW co-ordinators in Ellesmere Port
Commissioning contracts for Ellesmere Port projects	Nominated person in project organisation
Ellesmere Port programme launch event planning meeting notes	TW and no-TW providers and co-ordinators in Ellesmere Port
Ellesmere Port TW programme meeting minutes	TW Programme Manager in Ellesmere Port
Quarterly Ellesmere Port TW project monitoring reports	TW providers
Annual TW project audit reports	TW Programme Manager in Ellesmere Port
E-mails sent via TW Ellesmere Port programme e-mail circulation list	TW Programme Manager in Ellesmere Port
E-mails sent via TW portfolio circulation list	TW co-ordinators
Monitoring and evaluation guidance note version 1 Monitoring and evaluation guidance note version 2	North West Public Health Observatory evaluation team North West Public Health Observatory evaluation team

Evaluation Sub-group minutes	Meeting minute taker
TW portfolio 'outcomes' evaluation reports	NWPHO
TW portfolio process evaluation report	University of Central Lancashire research team
Ellesmere Port Area Partnership Board meeting minutes	Meeting minute taker
Ellesmere Port Community Sports Partnership minutes	Meeting minute taker

Appendix 6

Consent forms

INTERVIEW CONSENT FORM

Title of project: Target Wellbeing as a vehicle for social change

Name of Researcher: Katie Powell

Please tick each box if you agree with the statement

1. I have had and understand the information sheet about the research and have had the chance to ask questions. ☐

2. I understand that the interview/focus group will be audio recorded on a digital recorder. ☐

3. I agree to the researcher using direct quotes from the interview/focus group, as long as the quotes do not identify me. ☐

4. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

5. I agree to take part in the Target Wellbeing research. ☐

----------	----------	----------
Participant signature	Print name	Date
----------	----------	----------
Interviewer signature	Print name	Date

One copy to be taken by the participant and one by the interviewer

Appendix 7

Information sheets - service providers and co-ordinators

Research project: Target Wellbeing as a vehicle for social change

Katie Powell, University of Chester

Interviews: Information sheet for service providers

You are being asked to take part in a research project. Before you decide whether or not to take part, it would help if you know why this research is being done and what you will be asked to do if you agree to take part. Please read this sheet and discuss it with others if you wish. You can contact the researcher if anything is unclear or if you would like more information.

What is the research for?
The research is being done to investigate what happens when an area-based initiative like Target Wellbeing is implemented in a local area. The intended and unintended consequences of the Target Wellbeing initiative will be explored with focus on the social networks between service providers and local residents in Ellesmere Port. The research hopes to provide some insight into what scope area-based initiatives provide for health improvement.

Who is carrying out and paying for the research?
Western Cheshire Primary Care Trust and the University of Chester are jointly funding this study. The research will be carried out by Katie Powell, based at the University of Chester and will form the basis of her doctorate research (PhD). Professor Miranda Thurson is the supervisor for this study.

Why have I been chosen?
You have been asked to take part in an interview because you work in Ellesmere Port.

What will happen if I take part?
The researcher will contact you to arrange a convenient time to interview you. She will ask you to sign a consent form. The interview will last about an hour. If you agree, the researcher would like to audio record the interview. The audio recording will be stored on a password protected computer to which only the researcher, typist and research supervisor will have access. The audio recording will be destroyed at the end of the study, anticipated for June 2012.

Do I have to take part?
Taking part is voluntary. If you do not take part it will not affect your work in any way. If you decide to take part you will be asked to sign a form to say you have read this information about the research. Even if you decide to take part, you can stop at any time and you do not have to give a reason.

What are the advantages and disadvantages of taking part?
You may like the chance to share and discuss your experiences and to put forward your views. We do not think there are any disadvantages in taking part in the interview.

Will my taking part be kept confidential?
Taking part in this interview is anonymous and no names or details that could identify you would ever be used in any written or verbal reports.

What will happen to the results?
It is anticipated that the findings will be used to improve knowledge understanding about area-based initiatives. The Primary Care Trust will use the findings to inform future health improvement work in the area. The findings will be presented in a PhD thesis and papers from the findings will be submitted to relevant academic journals. Summaries of the findings will be made available to people who take part.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the Faculty of Applied and Health Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

Who can I contact if I want more information?
If you would like to know more about the interview you can contact the researcher, Katie Powell, Centre for Public Health Research, University of Chester, Parkgate Rd, Chester, CH1 4BJ. 01244 512058. k.powell@chester.ac.uk

Appendix 8

Interview schedule: service providers

Interview schedule: service providers

Interviewee background information (if not previously interviewed)

1. Can you describe briefly what your current role involves?
2. Can you tell me about working in Ellesmere Port?
    a. Had you worked in the area before Target Wellbeing?
    b. How has this impacted on your experience?

Health problems in Ellesmere Port

3. With regard to improving people's health in Ellesmere Port, what do you perceive the issues to be?
    a. Poor public services?
    b. Poverty?
    c. Social exclusion?
4. What do you think is the best approach to addressing some of these issues?
    a. Do local services have a role to play, if so what might this be?

Involvement in the health improvement and health inequalities agenda

5. Can you tell me about any work you have done in the field of health?
    a. Is this an area that your organisation has worked in before? Can you say more about this?
6. Are you involved in work to address health inequalities?
    a. What do you understand by the term health inequalities?
7. Has involvement with Target Wellbeing created any changes for your organisation?
    a. E.g. changes to the aims of your work or what you deliver?
    b. Created any opportunities for your organisation? E.g. have you made any new contacts or opportunities for further work?
    c. Has involvement created any challenges for your organisation? Can you provide details?

Relation to local and national strategies

8. Has the change in government or the local government reorganisation had any impact on your work, particularly in relation to TW?
    a. How do current government priorities relate to your work?
    b. Will the current priorities necessitate any changes to your work?
9. Has the recent financial crisis and current economic recession impacted on your work at all? Can you explain how?
10. Can you tell me about any other regional or national developments affecting the work of your organisation, particularly in relation to TW?

Development of the TW project

11. Can you tell me how things are developing with your TW project?
    a. Are you achieving targets set? Explore response
    b. Has the project developed as you anticipated? Explore response

12. Has TW funding enabled you to deliver what you wanted to do in Ellesmere Port? Can you say more about this?
13. Is there anything different about the ways in which you are working as part of your TW role compared to other work that you do in your organisation? Can you describe these differences?
14. Can you tell me about any changes that have been made to your project since it began?
    a. Why did these changes occur?
    b. How easy was it to implement the changes?

15. How does your TW project relate to the other TW projects in the Ellesmere Port programme, if at all?
    a. Have you collaborated with any other TW providers? Can you tell me about this?
    b. Did you have any plans to work with other TW providers?
    c. Is there any benefit to your TW work being managed within wider programme of TW projects?

16. Can you tell me about how your project fits with existing provision in Ellesmere Port?
    a. Is it important for you to work closely with other organisations or not?
    b. Can you tell me about any work you might do with other providers?
    c. How have other providers in Ellesmere Port responded to your project?

17. How do you think your TW project will achieve its aims and objectives?
    a. How were these plans developed?
    b. Can you give me any examples of how these plans are developing?

Relations with residents

18. Can you tell me about your work with local residents?
    a. How successful do you think the project has been in working with local residents?
    b. Can you say more about the processes through which you have developed relationships with residents?
        i. How do you make contact with residents?
        ii. What do you set out to achieve when contacting residents?
        iii. How do relationships develop? Can you give me any examples?

Change for residents

19. One of your project's aims is to improve 'community belonging' among residents. Can you tell me more about what this means?
    a. Why do you think this is important for the residents you work with?
    b. How do you aim to achieve this?
    c. To what extent is this happening? Can you provide any examples?
    d. Can you describe the ways in which any changes developed?

20. Are there any other ways that your project might influence changes among residents? Can you tell me more about these?

21. Is there anything else that you would like to discuss either about your experiences in Ellesmere Port or Target Wellbeing?

Appendix 9

Information sheet for residents

Research project: Target Wellbeing as a vehicle for social change

Katie Powell, University of Chester

Interviews: Information sheet for Target Wellbeing users

You are being asked to take part in a research project. Before you decide whether or not to take part, it would help if you know why this research is being done and what you will be asked to do if you agree to take part. Please read this sheet and discuss it with others if you wish. You can contact the researcher if anything is unclear or if you would like more information.

What is the research for?
The research is being done to look at what happens when an area-based project like Target Wellbeing is set up in a local area. The research will look at how well Target Wellbeing achieves what it has set out to do, and will also look at changes that might happen in the area that were not planned. A key concern of the research is the links between service providers and local people in Ellesmere Port. The research hopes to find out how area-based projects like Target Wellbeing can affect health.

Who is carrying out and paying for the research?
Western Cheshire Primary Care Trust and the University of Chester are paying for this study. The research will be carried out by Katie Powell, based at the University of Chester. Professor Miranda Thurson is the supervisor for this study.

Why have I been chosen?
You have been asked to take part in an interview because you have been to a Target Wellbeing activity in Ellesmere Port.

What will happen if I take part?
The researcher will contact you to set up a time to interview you. You will be asked to sign a form to say you have read this information about the research. The interview will last about an hour. The researcher will ask if you are happy to be interviewed again in a few months' time. If you are happy with this, the researcher will contact you again nearer the time.

Do I have to take part?
Whether or not you take part is up to you. If you do not take part it will not affect your use of any services in your area. Even if you decide to take part, you can stop at any time and you do not have to give a reason.

What are the advantages and disadvantages of taking part?
You may like the chance to talk about your experiences and to put forward your views. We do not think there are any disadvantages to taking part in the interview.

Will my taking part be kept private?
We will not tell anyone that you have taken part in the study. No names or details that could identify you would ever be used in any written reports or presentations.

What will happen to the results of the study?
The Primary Care Trust will use the findings to inform future health work in the area. The findings will be presented in a PhD thesis and the researcher will try to get them published in journals. Local residents can speak to Target Wellbeing project staff if they would like to see a summary of the findings or the whole report.

What if something goes wrong?
If you wish to complain or have any concerns about the way you have been contacted or treated during the course of this study, please contact Professor Sarah Andrew, Dean of the Faculty of Applied and Health Sciences, University of Chester, Parkgate Road, Chester, CH1 4BJ, 01244 513055.

Who can I contact if I want more information?
If you would like to know more about the research you can contact the researcher, Katie Powell, Centre for Public Health Research, University of Chester, Parkgate Rd, Chester, CH1 4BJ. 01244 512058. k.powell@chester.ac.uk

Appendix 10

Interview schedule: residents

Interview schedule

Pathways users

Background information

1. Do you mind telling me how old you are?
2. Do you mind if I take your postcode?

Living in Ellesmere Port

3. Can you describe for me what is it like living here from your point of view?
    a. How long have you lived in Ellesmere Port? What brought you to the area? Do you think you will always live here?
    b. Do you like living here?

Work

4. What do you do for a living, are you employed at the moment?
    a. **If yes**: what work do you do? Where are you based?
    b. Have you ever/always been based in Ellesmere Port for work?
    c. Can you tell me a little bit about your job?
    d. **If no**, are you looking for work or do you not work?
    e. Can you tell me a little bit about this experience?
    f. Have you ever worked locally?

Relationships

5. Can you tell me about the people in your life? Who do you usually spend time with?
    a. Friends/family/work colleagues/anyone else?
    b. Do you have friends and family in Ellesmere Port?
    c. Can you tell me a little bit about these relationships?
        i. Do you see these people often?
        ii. Under what sort of circumstances do you see them?
6. Can you tell me about your relationship with your neighbours?
7. Who do you usually call on for support? Can you tell me more about this?

Services in Ellesmere Port

8. Can you tell me about any services and facilities that you use locally?
    a. Do you use local shops; leisure facilitates; cafes; council services; parks and green spaces, community centres?
    b. **If not,** can you tell me why? Do you use any services or facilities elsewhere?
    c. **If yes,** Can you tell me about your experience of using these services and facilities?
9. What do you think of local public services in Ellesmere Port?
    a. For example, housing, transport, the healthy living centre, the EPIC, health services, schools, or the library etc.
    b. Can you tell me about your use of these services?
    c. If you don't use any services, why is this?
10. Do you use any voluntary or community-run services, e.g. the Citizen's Advice Bureau?

a. Can you tell me about any experiences using these services?
b. If you don't use any services, why is this?

Local places

11. Can you tell me about the areas in Ellesmere Port where you spend time?
    a. Town centre, particular wards, the retail park?
    b. How do you feel about spending time in those areas?
12. Can you tell me about other places that you spend time in locally?
        i. Do you spend time in nearby areas – Chester/Liverpool?
        ii. What do you do in those areas?
        iii. How do you feel about spending time there?

Local events and activities

13. Do you get involved with local events or activities? E.g. community fun days or any clubs or societies?
    a. Can you tell me about some of your experiences with these activities?
    b. What motivates you to take part? Are friends or family members involved?
    c. What do you get out of being involved in them?
    d. If you do not participate, what do you think of these types of activities?

Improving the area

14. What do they think would make it better to live in Ellesmere Port?
    a. Are changes needed to public services?
    b. Are different kinds of services needed?
    c. Are different employment opportunities needed?
    d. Something else?

Involvement with Pathways

15. Can you tell me about how you came to get involved with Pathways?
    a. Where did you hear about the activity and how did you get involved?
    b. Was there anything that motivated you to get involved?
    c. How did you feel about making contact with Pathways? Were you at all apprehensive or nervous about taking part? Can you say more about this?
16. How many sessions did you attend?
    a. Why did you stop using the service?
17. Can you tell me a little bit more about your involvement with Pathways? What activity did you attend?
    a. Can you tell me about the types of things that you have done with the service?
18. Have you ever used any other services that are similar to Pathways? Can you tell me a bit more about this?
19. How does your experience with Pathways compare to your experiences with other services or projects that you might have used?

20. Can you tell me about the people you have come into contact with through Pathways?
    a. What do you think of the staff at Pathways?
    b. What sort of things have you done with the staff?

c. Did you meet anyone new through the project? Can you tell me about your contact with other people using the services?
    i. Has this been of any benefit to you? In what ways?

21. Have you ever heard of Target Wellbeing or any of its projects (show the list of activities or describe what is being delivered)?
    a. **If yes,** Can you tell me about your experiences (refer to questions above)

Changes

22. Has anything in your life changed since you got involved with Pathways?
    i. Did the project put you in touch with any other services or activities locally?
    ii. Did you meet anyone new as a result of the project?
    iii. Do you do any new activities or go to any new places?
    iv. Have you changed your behaviour in any way?
    v. Have you done any volunteering?
    vi. Has the project changed the way you think about anything?
    vii. Have you changed your work?
    b. How have these changes benefitted you, if at all?

23. Thinking about your involvement with the project, what do you think will happen in the future?
    a. Will you keep doing any new activities that you have started?
    b. Will you stay in contact with new friends?
    c. Will you use any different services?

24. Is there anything else you want to say about living in Ellesmere Port or your experiences with Pathways?

Appendix 11

Target Wellbeing project descriptions as set out in the BIG Lottery funding application

Footprints

The Community Walking Programme will establish a series of volunteer-led walks from local community centres within three deprived communities in order to increase access to physical activity.

Research shows that activities which are delivered in a group or social environment are more likely to sustain commitment and interest. Group walking can also reduce social isolation and help improve mental well-being. Lessons learned from the Walking for Health Initiative will be factored into the design of the scheme.

The project will produce a series of Planned Walking Route Leaflets covering these three areas to encourage independent walking activities and promote an active lifestyle for those not able to participate in the led walk activities.

The project will also provide pedometers for use by individuals / groups within the area as a motivational tool to encourage individuals to continue to be active. Project monitoring will focus on sustained lifestyle changes over a period of time.

The areas covered by this project have high indices of multiple deprivation. A local walking scheme will provide access to a low cost form of physical activity that has the ability to reach large numbers of the community.

Funding will employ a part-time co-ordinator and printing / promotion costs.

Get Involved, Get Active

Get Involved, Get Active targets excluded and/or isolated older people, aiming to increase well-being through an arts initiative and an allied range of physical activity sessions and themed activity weeks. 5 classes per week of 12 week courses will be delivered.

The arts element of the project will introduce the 'Wearpurple' arts initiative to the local area which aims to reduce social isolation. This will give older people the opportunity to work with professional artists to create new artwork and performances.

In addition, Age Concern Cheshire will encourage older people to engage in a healthier lifestyle by open access to exercise/activity schemes, for example, Tai-Chi, yoga, seated chair exercise, postural stability, etc.

The project will also include 8 "healthy weeks", for example:
Stroke Assessment week
Blood Pressure Checks week
Diabetes week
Good Nutrition & Healthy Eating week
Footcare week
Your Rights week

It is anticipated that referrals for the elements of the project will come via GP surgeries, Social Services, Ellesmere Port Hospital, the Healthy Living Centre, day care clients and other community organisations through the Ellesmere Port Community Sports Network.

The grant will pay primarily for a part-time co-ordinator and admin support, and the costs of tutors and equipment.

Grab a Bag

Community Health Workers – Grab a Bag will recruit local people into the roles of Community Health Workers. The workers will be trained to provide practical advice to local people on diet and nutrition and implement a school playground and Children's' Centre fruit and vegetable scheme. The workers will provide "support from next door" by living and working in the communities they serve.

A partnership between Heart of Mersey and Western Cheshire PCT's Specialist Health Improvement Service will oversee the implementation of the project.

The project aims to provide an increase in the numbers of people accessing affordable fruit and vegetables in the most deprived and marginalised communities within the borough of Ellesmere Port and Neston by:

- Increasing availability of fruit and vegetables via school playgrounds and Children's Centres based fruit and vegetable bag schemes
- Providing practical help and support to beneficiaries on cooking skills recipe development.
- Improving literacy and numeracy skills through beneficiary attendance at accredited healthy eating courses

Funding will pay for the employment of two community health workers (part-time) plus training, promotion of the scheme and purchase of fruit and vegetables.

Lots of plots

The 'Lots of Plots' project will encourage local communities and targeted groups to discover the health benefits associated with growing their own food, through the provision of a programme of activity that will be both educational and enjoyable. Growing food in any setting will be encouraged from the traditional allotments, to growing food in small planters either in school, at home or in community centres.

The project will:

- deliver 6 community based introductory food growing sessions per year, with a minimum of 10 participants per session;
- Establish a community allotment site;
- Deliver a programme of practical activities on-site – minimum of 12 sessions per year;
- Organise a variety of practical hands-on horticultural sessions for adults and children;
- Develop links between allotments and schools and enable experienced plot holders to share their knowledge
- Establish growing clubs in 3 Primary Schools.
- Provide 3 primary schools with 3 food-growing activities per term for 4 years.
- Provide 6 x 2 hour food growing / healthy eating workshops at High School

The grant will pay for

- Project Officer time to implement, monitor and evaluate the project and to provide practical horticultural support and advice.
- Tools and equipment, training and activities.
- Allotment plot construction materials

Mental health and wellbeing

CHAPTER works to help people who have, or have had, mental health problems, and who are disadvantaged in the jobs market. To achieve this, CHAPTER:

- assists participants to prepare themselves for job readiness through assessment and personal development programmes to assist in the acquisition of the soft skills necessary to help combat stigma and social exclusion.
- seeks out relevant educational opportunities in basic and wider skills.
- offers a programme of targeted learning, individually, and in groups, which is accredited by the National Open College Network.
- encourages positive actions by employers in favour of people who have had, or continue to have, mental health problems.
- negotiates work experience placements.
- uses job training schemes.

The project will focus primarily on interventions to prepare beneficiaries for employment. CHAPTER employs a placement officer, as well as there being other providers locally to whom beneficiaries can be referred for support directly into employment.

Beneficiaries will have access to the full range of programmes CHAPTER offers, including the 'Gardening Project' (service to local elderly and disabled people), which provides a venue for supervised work placements.

The grant will pay for staffing the project.

Out and About

This project will fund a Community Out and About Officer to work with local communities and partner organisations to encourage local people to more fully utilise their local parks and green spaces as a leisure and healthy lifestyles resource. The project officer will lead a programme of activity each year including:

- Wild flower seed collection and sowing;
- Informal guided walks to explore the changing seasons within the local parks and open spaces;
- Organised cycle rides, including cycle proficiency training;
- Cycle and walking leader training for volunteers;
- Visits to other local nature sites;
- Organised conservation volunteering sessions;
- Events and workshops to encourage independent outdoor leisure.

The project will:

- Establish parks and local green space as a focus for community events and activities;
- Encourage people to increase their levels of physical activity through walking and cycling;
- Encourage volunteers to support practical activities in local parks and green space
- Encourage local people to become walks and cycle leaders;

- Encourage local people to become involved in 'Friends of' Groups;

Grant Will Pay for:
- Project Officer time to manage, deliver, monitor and evaluate the project.
- Events and activities
- Tools and equipment to support activities
- PR products and events

Pathways

Employment and learning are key determinants of health. This project will use employability as a mechanism of improving the mental health of unemployed people from the targeted wards of Ellesmere Port and Neston.

The project will support unemployed people to improve their mental health by enabling them to move closer to employment through provision of work experience. The project recognises that employers' attitudes towards unemployed individuals is to see them as a risk and it will seek to challenge that stigma.

The project will focus on organisational workforce shortages, creating opportunities for local unemployed people, specifically lone parents and people with disabilities.

The project will deliver intensive interventions to its clients over a period of between 32-42 weeks, including:
- Provision of information, advice and guidance and basic skills support
- Preliminary training – Health and Safety, first aid, et al
- Identifying suitable placements and employer liaison
- Support on placement

The project will link with other local initiatives – both within this portfolio and mainstream provision – to ensure seamless provision without duplication of activity.

The grant will pay beneficiary costs of attending work experience, employment of a part-time Employability Advisor, production of promotional materials and the delivery of positive employment support to employers.

Workplace Wellbeing

The Workplace Well-being Project will provide workplace health advisors in GP surgeries, community settings and workplaces in targeted areas of Ellesmere Port and Neston.

The advisors will offer comprehensive workplace health and well-being advice and support to individuals and their employers. Referral will be by self-referral, via clinical staff, employers, other statutory and voluntary sector agencies or from links with other primary care agencies such as Community Mental Health Teams and local NHS Walk-in Centres. Using a case management approach the service will link with other agencies providing further support.

Expected achievements will be to:

- Contribute to ensuring healthier work environments, to improve the physical and mental well-being of individuals.
- Support people experiencing ill health to remain in employment
- Lessen impact on GP time
- Reduce sickness absence and improve productivity
- Support employers to provide better environments to support healthier lifestyle choices, particularly around diet and activity
- Promote the use of the workplace as a setting to promote public health
- Provide an exemplar of partnership working

The project will aim to demonstrate the effectiveness of using workplaces as a setting for public health improvement, and thus demonstrate the value of mainstreaming these activities.